

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF OHIO  
EASTERN DIVISION  
CAUSE NO. 17-md-2804  
MDL NO. 2804

IN RE: NATIONAL )  
PRESCRIPTION OPIATE )  
LITIGATION )  
THIS DOCUMENT RELATES TO: )  
TRACK THREE CASES )

REMOTE VIDEO DEPOSITION OF  
CARMEN A. CATIZONE, MS, RPh, DPh  
VOLUME II

The deposition upon oral examination of  
CARMEN A. CATIZONE, MS, RPh, DPh, a witness produced  
and sworn before me, Amy Doman, Registered Merit  
Reporter, Certified Realtime Reporter, Certified  
Shorthand Reporter, Notary Public in and for the  
County of Hamilton, State of Indiana, taken on behalf  
of the Defendants, in Mount Pleasant, South Carolina,  
scheduled to begin at 8:00 a.m., on Wednesday,  
June 16, 2021, pursuant to the Federal Rules of  
Civil Procedure.

1 A P P E A R A N C E S  
2 ON BEHALF OF THE PLAINTIFFS:

3 MOTLEY RICE LLC

4 BY: Michael E. Elsner

Courtney R. Wolf

James Ledlie

5 Kaitlyn Eekhoff

28 Bridgeside Boulevard

6 Mount Pleasant, South Carolina 29464

(843) 216-9000

7 Melsner@motleyrice.com

cwolf@motleyrice.com

8 jledlie@motleyrice.com

keekhoff@motleyrice.com

9 SPANGENBERG SHIBLEY & LIBER LLP

10 Peter H. Weinberger

1001 Lakeside Avenue East

11 Suite 1700

Cleveland, OH 44114

12 (216) 600-0114

pweinberger@spanglaw.com

13 ON BEHALF OF DEFENDANTS CVS PHARMACY, INC.;  
14 CVS INDIANA, LLC; CVS Rx SERVICES, INC.;  
15 CVS TN DISTRIBUTION, LLC; OHIO CVS STORES, LLC:

16 ZUCKERMAN SPAEDER LLP

BY: Graeme W. Bush

100 East Pratt Street

17 Suite 2440

Baltimore, MD 21202-1031

18 (410) 949-1159

gbush@zuckerman.com

19 ZUCKERMAN SPAEDER

20 BY: Jason B. Acton

1800 M Street Northwest

21 Suite 1000

Washington, DC 20036-5807

22 (202) 778-1800

jacton@zuckerman.com

1 Appearances (Continued):

2 ON BEHALF OF DEFENDANTS GIANT EAGLE, INC.;  
3 HBC SERVICE COMPANY:

4 MARCUS & SHAPIRA, LLP

5 BY: David Zwier

6 Joshua A. Kobrin

7 One Oxford Centre, 35th Floor

8 Pittsburgh, PA 15219

9 (412) 338-5214

10 zwier@marcus-shapira.com

11 kobrin@marcus-shapira.com

12 ON BEHALF OF DEFENDANT WALMART, INC.:

13 JONES DAY

14 BY: Tara A. Fumerton

15 77 West Wacker, Suite 3500

16 Chicago, IL 60601-1692

17 (312) 269-4335

18 tfumerton@jonesday.com

19 JONES DAY

20 BY: John D. Goetz

21 500 Grant Street, Suite 4500

22 Pittsburgh, PA 15219-2514

23 (412) 394-7911

24 jdgoetz@jonesday.com

25 ON BEHALF OF DEFENDANT RITE-AID:

MORGAN LEWIS & BOCKIUS LLP

BY: John Gisleson

1701 Market Street

Philadelphia, PA 19103-2921

(215) 963-5328

john.gisleson@morganlewis.com

ON BEHALF OF DEFENDANTS WALGREENS BOOTS ALLIANCE,  
INC.; WALGREEN CO.; AND WALGREEN EASTERN CO., INC.:

BARTLIT BECK LLP

BY: Brian C. Swanson

1801 Wewatta Street

Suite 1200

Denver, CO 80202

(303) 592-3197

brian.swanson@bartlitbeck.com

Appearances (Continued):

LEVIN PAPANTONIO RAFFERTY

BY: Laura Dunning

Page Poerschke

316 South Baylen St.

Pensacola, FL 32502

(205) 396-5014

ldunning@levinlaw.com

ppoerschke@levinlaw.com

VIDEOGRAPHER:

Robert Miller

ALSO PRESENT:

Jonathan Jaffe

David R. Cohen

Special Master

DAVID R. COHEN CO. LPA

24400 Chagrin Boulevard, Suite 300

Cleveland, Ohio 44122

(216) 831-0001

david@specialmaster.law

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

INDEX OF EXAM

Page

CROSS-EXAMINATION (Continued) ..... 344  
Questions by Brian C. Swanson

CROSS-EXAMINATION..... 417  
Questions by John Gisleson

CROSS-EXAMINATION..... 463  
Questions by Joshua Kobrin

REDIRECT EXAMINATION..... 509  
Questions by Tara Fumerton

CROSS-EXAMINATION..... 517  
Questions by Michael Elsner

RECROSS-EXAMINATION..... 522  
Questions by Joshua Kobrin

INDEX OF EXHIBITS

Deposition Exhibits: Page

Exhibit 16 - August 014 Model State ..... 359  
Pharmacy Act and Model Rules  
of the National Association  
of Boards of Pharmacy

Exhibit 17 - May 2011 newsletter from the .. 369  
Ohio state board of pharmacy

Exhibit 18 - Email dated 3/10/2015..... 385

1 THE VIDEOGRAPHER: Good morning. We're going  
2 on the record at 8:09 a.m. Eastern time on  
3 June 16th, 2021. This is Media Unit Number 1,  
4 Volume 2 of the video-recorded deposition of Carmen  
5 Catizone taken in the matter of In Re: National  
6 Prescription Opiate Litigation from the  
7 U.S. District Court for the Northern District of  
8 Ohio, Eastern Division, Case Number 17-md-2804.

9 This deposition is being held remotely. My  
10 name is Kraig Hildahl from the firm Veritext Legal  
11 Solutions, and I'm the videographer. The court  
12 reporter today is Amy Doman, also with Veritext.

13 Will counsel please identify themselves for  
14 the record.

15 MR. SWANSON: We have all counsel on the  
16 transcript, Amy. Can we just proceed? Is that  
17 okay?

18 THE REPORTER: Yes, sir. Thank you.

19 CROSS-EXAMINATION (continued)

20 QUESTIONS BY BRIAN C. SWANSON:

21 Q Good morning, Mr. Catizone.

22 A Good morning, Mr. Swanson.

23 Q How are you this morning, sir?

24 A I'm fine, thank you.

25 Q Terrific. Can you pull out and put in front of you

1 Exhibit 2, which is your supplemental report in  
2 this case?

3 A Yes, sir.

4 Q Do you have that in front of you now?

5 A Yes, sir.

6 Q Great. Other than that report, do you have any  
7 other notes, documents, or aids, either paper or  
8 electronic with you today?

9 A Yes, sir.

10 Q What else do you have?

11 A I have all of the exhibits from yesterday on the  
12 desk. I have a blank pad of paper for notes, and I  
13 have a pen and that's it, sir.

14 Q Okay. So you don't have any electronic media or  
15 anything with notes or guides for you?

16 A No, sir.

17 Q Okay. Thank you for confirming that.

18 Before we launched, you also have the box of  
19 possible exhibits that my firm sent over to you?

20 A Let me check, please.

21 Q Sure.

22 A Yes, sir.

23 Q Okay. Now I can assure you that we're not going to  
24 go through all of those documents, so you don't  
25 have to worry about that, but I'll try to, as we

1 go, identify the ones that we might need so you can  
2 put those in front of you if you would like to.

3 Okay?

4 A Yes, sir.

5 Q Great. Can you please open up your expert report,  
6 Exhibit 2, to page 10.

7 A I'm there, sir.

8 Q Page 10, if you just flip back one page, this is  
9 the section of your report regarding what you call  
10 "Corporate Oversight."

11 Do you see that?

12 A Yes, sir.

13 Q On page 10 in the middle paragraph, the one that  
14 begins "Chain Pharmacies." Can you go to that  
15 paragraph?

16 A Yes, sir.

17 Q About midway through, you write: "Pharmacies must  
18 maintain systems and methods to store and retain  
19 prescription dispensing data and records."

20 Do you see that sentence?

21 A Yes.

22 Q And then the final sentence of that paragraph, it  
23 continues: "Pharmacies must utilize their  
24 information to identify patterns of diversion to  
25 audit the work of their pharmacists, to train its



1 pharmacy personnel, investigate suspicious  
2 prescribers, patients, and pharmacists, and to  
3 prevent diversion of controlled substances."

4 Did you write that, sir?

5 A Yes, sir.

6 Q Is it your opinion that every licensed pharmacy in  
7 Ohio is required to use its dispensing data to  
8 identify patterns of diversion?

9 A Yes, sir.

10 Q Is it your opinion that every licensed pharmacy in  
11 Ohio is required to use its dispensing data to  
12 audit the dispensing of the pharmacists?

13 A Yes, sir.

14 Q Is it your opinion that every licensed pharmacy in  
15 Ohio is required to use its dispensing data to  
16 investigate suspicious prescribers, patients, and  
17 pharmacists?

18 A Yes, sir.

19 Q If I understand your report and the content of your  
20 report, to you that means that the pharmacies must  
21 create systems that use dispensing data to alert  
22 pharmacists at the store level of certain red flags  
23 that you have created when those red flags are  
24 triggered; is that accurate?

25 A Yes, sir.

1 Q If you flip back to page 9, again, in the corporate  
2 oversight, you write that: "These  
3 responsibilities" -- that we've just been  
4 discussing -- "are reflected in the Controlled  
5 Substances Act and relevant Ohio state law."

6 Is that your opinion?

7 A Yes, sir.

8 Q Now, when you say that those -- what you call  
9 responsibilities are reflected in the Controlled  
10 Substances Act and relevant in Ohio state law, you  
11 don't provide any citation to what provisions of  
12 the CSA or Ohio state law you are referring to; is  
13 that right?

14 MR. ELSNER: Objection.

15 A Not in this section, sir.

16 BY MR. SWANSON:

17 Q So can you tell me what provision of the Controlled  
18 Substances Act states the pharmacy must use its  
19 dispensing data to identify patterns of diversion  
20 in the way that you have opined in your report?

21 A There are two or three sections within the CSA that  
22 I cannot cite specifically, but I can explain.

23 If there's a copy you could provide or if I  
24 have a copy of the CSA, I could point out those  
25 specific provisions. But the sections are, one,

1           that says that a pharmacy must maintain appropriate  
2           records and controls for controlled substances.

3           That is the part that says that they must have  
4           dispensing records, and the dispensing data must be  
5           appropriate for the distribution and control of  
6           controlled substances.

7           And then the second section talks about being  
8           able to identify diversion, abuse, and a fraud. So  
9           as a pharmacist and as a regulator for 35 years,  
10          those sections, to me, and to pharmacists,  
11          represent my opinion and the basis for my opinions.

12        Q     Can you help me by identifying by number the  
13              provision that you are relying upon?

14              MR. ELSNER: Objection.

15        A     I don't have it in front of me, but it would be  
16              part of 1306.04, .06, those two sections of the  
17              provisions of the Controlled Substances Act.

18              BY MR. SWANSON:

19        Q     So you are relying on 1306.04, which is the  
20              "Corresponding Responsibility" section?

21        A     Correct.

22        Q     That's one of the sections you're relying on?

23        A     One of the sections, sir.

24        Q     Okay. And if you turn to page 25, we looked at  
25              that yesterday. You've quoted that provision in

1 its entirety. So why don't you turn to 25.

2 A I'm there.

3 Q Okay. And you can see where you've quoted 1306.04.

4 Can you show me where in 1306.04 it states  
5 that a pharmacy must use its dispensing data to  
6 identify patterns of diversion?

7 MR. ELSNER: Objection.

8 A Again, sir, as I explained yesterday, the  
9 application of 1306.04 and 1306.06 and the  
10 interpretation based upon my experience in this  
11 area and regulation, is where the basis for my  
12 opinion comes from.

13 BY MR. SWANSON:

14 Q All right. I just want to make sure I am clear,  
15 then, on your testimony. When you say that the  
16 pharmacist -- the pharmacy's obligation to use  
17 dispensing data to identify patterns of diversion  
18 is required by the Controlled Substances Act, the  
19 provisions that you rely upon are 1306.04 and  
20 1306.06; is that correct?

21 MR. ELSNER: Objection.

22 A In part, sir. It's the entire CSA.

23 BY MR. SWANSON:

24 Q Okay. Well, I want to know -- and I'm asking if  
25 you can identify anywhere in the CSA where it

1 states that a pharmacy has an obligation to use its  
2 dispensing data to identify patterns of diversion.  
3 Is there anywhere in the CSA that specifically  
4 requires that obligation?

5 MR. ELSNER: Objection.

6 A Specifically, the CSA identifies pharmacy as a  
7 practitioner, as the DEA has. And therefore, the  
8 same responsibilities that a pharmacist has is on a  
9 pharmacy. And if I can, if I can point you down to  
10 the next paragraph and the testimony of Demetra  
11 Ashley from the DEA who said that the obligation to  
12 identify any red flags relating to a  
13 controlled-substance prescription to resolve them  
14 before filling a prescription, and to document any  
15 resolution of red flags is a well-recognized  
16 responsibility of the pharmacist in the  
17 professional practice of pharmacy.

18 And since the DEA has interpreted practitioner  
19 to mean pharmacy, corporation, and pharmacist, that  
20 also is the basis of my opinion in this report.

21 BY MR. SWANSON:

22 Q Okay. But right now, I want you to stick with me,  
23 okay? I'm asking you about the Controlled  
24 Substances Act and any specific provisions. I'm  
25 not asking you about what another witness might

1           have said. And I can go -- we can go there if you  
2           want to.

3                   But I first want to get your testimony about  
4           what specific provisions you would rely on when you  
5           are testifying in court and saying that the  
6           defendants violated because they didn't have -- if  
7           they didn't have the systems that you claim they  
8           should have had. Do you understand the question  
9           I'm asking you?

10                   MR. ELSNER: Objection.

11       A       I do, sir, but I don't think you're understanding  
12       my answer. So my answer is that the Controlled  
13       Substance Act in its entirety forms the basis and  
14       that each individual provision within there was  
15       used to substantiate my position. I've explained  
16       to you that the provision that says the appropriate  
17       dispensing and recordkeeping, although it may not  
18       specifically say what they're to do to the utmost  
19       detail, that is the basis for my opinion and those  
20       are the provisions that I've used.

21                   And that's the answer I've been giving you  
22       several times and the same answer I will give  
23       repeatedly if you continue to ask that question.

24                   BY MR. SWANSON:

25       Q       Let me see if we can at least get agreement on

1           this. Sitting here today in response to my  
2           questions to what provisions of the CSA, in your  
3           view, require a pharmacy to use dispensing data to  
4           identify patterns of diversion, the two provisions  
5           that you've provided to me sitting here today are  
6           1306.04 and 1306.06; is that true?

7           A     No, sir.

8                     MR. ELSNER: Objection, asked and answered.

9           A     You asked me that question, I've answered a couple  
10           times saying that those are some of the provisions.  
11           My answer is all of the CSA, all provisions, form  
12           the basis for that responsibility.

13           BY MR. SWANSON:

14           Q     Okay. So 1306.07, that's one?

15           A     I've said all of the provisions of the CSA taken in  
16           total are the basis for my opinions, sir.

17           Q     Any state law that you rely on for your opinion  
18           that a pharmacy is required to use its dispensing  
19           data to identify patterns of diversion?

20           A     Again, the state law mimics federal law and  
21           pharmacists in states are responsible to comply  
22           with federal law. So my answer would be the same.  
23           The CSA in its entirety is the basis for  
24           pharmacists at the state level to also comply with  
25           that responsibility in my opinion.

1 Q So it's your opinion that if a pharmacy -- and go  
2 outside of Ohio. Any pharmacy in the United States  
3 that isn't using its dispensing data to provide the  
4 pharmacists at the counter with information to  
5 identify patterns of diversion, that pharmacy is in  
6 violation of the Controlled Substances Act? Is  
7 that your testimony?

8 MR. ELSNER: Objection.

9 A It's my opinion that that pharmacy, then, is not  
10 instituting, implementing, and enforcing  
11 appropriate controls for the distribution and  
12 dispensing of controlled substances. So my answer  
13 is yes.

14 BY MR. SWANSON:

15 Q And can you identify for me a pharmacy anywhere in  
16 the country that uses its dispensing data to  
17 identify patterns of diversion that are provided to  
18 the pharmacists prior to dispensing a medication?

19 MR. ELSNER: Objection.

20 A I can't specifically identify, but I can identify  
21 that the defendants in this case did not do so, and  
22 therefore, didn't meet the standard of care.

23 BY MR. SWANSON:

24 Q And I understand that's your opinion. But my  
25 question was a bit broader.



1           Can you identify a pharmacy anywhere in the  
2           country that uses dispensing data to identify  
3           patterns of diversion that are then provided to  
4           pharmacists prior to dispensing medication. I'm  
5           not limiting it. Anywhere in the country, can you  
6           point to a pharmacy?

7           MR. ELSNER: Objection.

8       A     I can't point to one today, but I would be glad to  
9           do the research and find a pharmacy for you. I'm  
10          sure they exist out there.

11       BY MR. SWANSON:

12       Q     Well, I mean, you worked for the NABP for 30 years.  
13           I imagine you must have interacted with pharmacies  
14           quite a lot in that position, didn't you, sir?

15       A     Yes, I did.

16       Q     And you worked at a pharmacy, you said, all the way  
17           through 2004, you were working as a pharmacist,  
18           right?

19       A     Yes, sir.

20       Q     And given all of that experience and all of those  
21           interactions with pharmacies all over the country,  
22           and boards of pharmacy all over the country,  
23           sitting here today you can't identify a single  
24           pharmacy anywhere in the country that uses  
25           dispensing data to identify patterns of diversion

1           provided to pharmacists prior to dispensing a  
2           medication, true?

3           MR. ELSNER: Objection.

4       A     No, sir. Thanks to you refreshing my memory, I can  
5           say for certain that the pharmacy I worked at in  
6           Albertsons chain pharmacy uses dispensing data and  
7           provides that dispensing data prior to the  
8           pharmacist dispensing prescriptions.

9       BY MR. SWANSON:

10      Q     How does their system work?

11      A     I don't know the mechanics behind it, sir. I know  
12           that they provide dispensing data to the  
13           pharmacists as part of the process before  
14           dispensing a prescription.

15      Q     When is the last time you saw the Albertsons'  
16           dispensing data or dispensing system?

17      A     I reviewed their error reporting and dispensing  
18           system about three weeks ago, sir.

19      Q     Do you do consulting for Albertsons?

20      A     No, sir, I don't.

21      Q     So what was -- why were you reviewing their error  
22           reporting and dispensing system three weeks ago?

23           MR. ELSNER: Objection.

24      A     It was for another client, sir.

25      BY MR. SWANSON:

1 Q And what was -- what was the reason that you were  
2 reviewing their reporting and dispensing system?

3 A The client that I am working with has a system that  
4 will centralize the distribution management of the  
5 COVID vaccine for pharmacies and integrate that  
6 into their dispensing system, as well as provide  
7 alerts to patients. As so as part of that process,  
8 we reviewed their dispensing process to determine  
9 what alerts the pharmacist receives, and at what  
10 point the pharmacists would be able to utilize this  
11 system and an error reporting system as part of the  
12 dispensing process.

13 Q And is it your testimony that this system at  
14 Albertsons that you say you looked at recently,  
15 will alert a pharmacist of patterns of diversion?

16 MR. ELSNER: Objection.

17 A No, sir, your question to me was, was I aware of  
18 any pharmacy in the United States that used  
19 dispensing data to alert pharmacists or to provide  
20 pharmacists with information about diversion.

21 MR. ELSNER: Objection.

22 A And Albertsons provides that information. I'm not  
23 sure what the alert system is for that. But I know  
24 dispensing data is one of the tools and information  
25 provided to pharmacists as they dispense

1           prescriptions.

2           BY MR. SWANSON:

3           Q     But does this Albertsons' system that you now say  
4                 provides this information, does it alert the  
5                 pharmacist at the counter of a potential pattern of  
6                 diversion like you say is required under the CSA?

7                 MR. ELSNER:  Objection.

8           A     Two points, sir, if I can.  One, I did not say it  
9                 was required at the counter.  I said they had to  
10                have a system that uses dispensing data that  
11                provides information to the pharmacists prior to  
12                dispensing the prescription.

13               Second, I do not know Albertsons' system  
14               enough to comment on that.  So I would have to say  
15               I don't know about that.

16           BY MR. SWANSON:

17           Q     We talked a bit yesterday when you were with the  
18                 NABP, one of the things that the NABP did is you  
19                 would publish -- you would write and then publish  
20                 model rules and model acts that you would provide  
21                 to the state.

22                 Do you recall that?

23           A     Yes, sir.

24           Q     If you can open up please the folder that's marked  
25                 WAG19-1-9.  I'm going to try to introduce this as

1 an exhibit online too.

2 A You mean WAG 19, not WAG 19-1-9, not 1919, just  
3 WAG 19, right?

4 Q Yes, sir, one, nine.

5 And can I ask the court reporter what exhibit  
6 I should mark this as.

7 THE REPORTER: This will be 16.

8 (Exhibit 16 was marked for identification.)

9 A I have it open, sir.

10 BY MR. SWANSON:

11 Q And I'm going to -- I'll publish it to or at least  
12 introduce it so everybody can have it. Okay.

13 Exhibit 16 is a document, an "August 014 Model  
14 State Pharmacy Act and Model Rules of the National  
15 Association of Boards of Pharmacy"?

16 Is that what you have in front of you?

17 A Yes, sir.

18 Q Terrific. We're on the same page, then.

19 So I just read the title of Exhibit 16. Are  
20 these -- is this an example of the model rules and  
21 regulations that the NABP would publish when you  
22 were there?

23 A Yes, sir.

24 Q You're familiar with this document, right?

25 A Yes, sir.

1 Q Who drafts this document? Is it sort of a team  
2 effort at NABP?

3 A Yes, sir.

4 Q What's your contribution or what was your  
5 contribution to the model act in 2014?

6 MR. ELSNER: Objection.

7 A I provide the final staff review before it's  
8 presented to the board of directors for ultimate  
9 approval.

10 BY MR. SWANSON:

11 Q Okay. So when this -- when the Model State  
12 Pharmacy Act goes out and gets published, it has  
13 your sign-off, right?

14 A Yes, sir.

15 Q I think you said yesterday that the model act  
16 describes what you'd call best practices for state  
17 boards to try to implement; is that right?

18 A Yes, to some degree, sir.

19 Q Now, if you look at the table of contents on the  
20 third or fourth page, you can see there's a section  
21 for "Model Rules for the Practice of Pharmacy."

22 A Yes, sir.

23 Q And I can -- I can publish this if that makes it  
24 easier for everybody. At least I think I can.

25 MR. SWANSON: How did I do, is everybody

1           seeing the Exhibit 16?

2           MR. ELSNER:   Yes.

3           MR. SWANSON:   Okay.   Thank you.

4       BY MR. SWANSON:

5       Q     So Mr. Catizone, you can see if you scroll down  
6           three or four pages, there's a section there Model  
7           Rules for the Practice of Pharmacy.   Do you see  
8           that?

9       A     Yes, sir.

10      Q     And one of the sections you can see in there is  
11           automated pharmacy systems; is that right?

12      A     I can't see it on the screen, but I believe it's  
13           there, sir.

14      Q     All right.   I can --

15           MR. ELSNER:   Carmen, take the time if you  
16           can't see it on the screen to refer to --

17      BY MR. SWANSON:

18      Q     Or you can look at whichever one is easier for you,  
19           sir.   I just have it up so everyone can see it.

20           MS. FUMERTON:   Brian, it's a little small if  
21           you can make it bigger.

22           MR. SWANSON:   I sure can.   Thanks.

23           MR. ELSNER:   Mr. Catizone, it's on the  
24           page that ends 9630.

25           THE WITNESS:   Okay.   Thank you.

1 BY MR. SWANSON:

2 Q Are you there?

3 A Yes, sir.

4 Q Okay. And again, and what are automated pharmacy  
5 systems?

6 A They're a variety of systems. They can be the  
7 dispensing process, they can be the pill-counting  
8 machines, it's technology utilized within the  
9 pharmacies.

10 Q And is it the automated pharmacy system that, in  
11 your view, would be the system that should alert a  
12 pharmacist to potential patterns of diversion?

13 A It would be one of the systems, sir.

14 Q And then if you go down -- or if you flip your copy  
15 in to page 91, you'll see the section on automated  
16 pharmacy systems. And you'll get there faster than  
17 I will, because there's really no good way to do  
18 this on the screen. But if you turn to page 91?

19 A Yes, sir.

20 Q Okay. Page 91 you can see is Section 8 and it's on  
21 "Automated Pharmacy Systems," right?

22 A Yes, sir.

23 Q Now, is there anywhere in the section that you and  
24 your team put out on automated pharmacy systems  
25 that requires a pharmacy to implement a system



1           where it uses its dispensing data to identify  
2           patterns of diversion? Can you point me anywhere  
3           in the section that you signed off on that says  
4           that that's a requirement?

5           MR. ELSNER: Objection.

6       A     Yes, sir.

7       BY MR. SWANSON:

8       Q     Okay. Where?

9       A     Can I explain and then point to the section at the  
10           same time, sir?

11      Q     You can answer it however you feel appropriate.

12      A     Thank you.

13           So the Model State Pharmacy Practice Act is  
14           reflective of what occurs at the state level. And  
15           perhaps just as an explanation, what is contained  
16           in the act is very relevant and forms the basis of  
17           the model rules.

18           And the model rules then reflect the  
19           interpretation and implementation of the act. In  
20           the act it talks about the practice of pharmacy.  
21           It talks about drug utilization review, and it  
22           talks about prospective drug utilization review.  
23           In this particular section on page 92 on Number 5  
24           at the bottom, it says: "Records and/or electronic  
25           data kept by automated pharmacy systems shall meet

1 the following requirements. All events involving  
2 the contents of the automated pharmacy system must  
3 be recorded electronically."

4 So taking the practice act, which requires the  
5 pharmacist to appropriately dispense prescriptions,  
6 resolve red flags and document that, this system  
7 then must have some way of recording that  
8 electronically, whether it's part of the alerts for  
9 the pharmacist, or whether there are other tools  
10 that are available to the pharmacist.

11 That's the interpretation of NABP and the  
12 guidance to the states to -- in direct response to  
13 your question.

14 Q Okay. I thought I heard you talking about  
15 documentation.

16 My question was focused on this requirement  
17 where you say that every pharmacy in the country is  
18 required to have a -- to use its dispensing data to  
19 identify patterns of diversion at the pharmacy  
20 counter. And I'm wondering if that requirement,  
21 that you now say is a requirement, is included  
22 anywhere in the model rules that you signed off on?

23 MR. ELSNER: Objection, asked and answered.

24 A And my answer was, yes, sir. The model rules must  
25 be implemented in accordance with the practice act

1 as with state law. There are no model rules that  
2 exist without an existing state law. The practice  
3 act forms the basis for that requirement of the  
4 dispensing data being utilized as part of the  
5 appropriate controls for dispensing controlled  
6 substances. The model rules then further identify  
7 in terms of technology and operations, what those  
8 events are and the rules say all events, which  
9 would include utilizing dispensing data to ensure  
10 the appropriate dispensing drug utilization review  
11 and distribution of prescriptions.

12 BY MR. SWANSON:

13 Q I'm not asking -- sir, I'm not asking about drug  
14 utilization review. I'm asking about the system  
15 that you talk about in your report, right? Is a  
16 system where you say a pharmacy has to use  
17 dispensing data to identify patterns of diversion,  
18 and then notify the pharmacist at the store level  
19 of a possible red flag.

20 That's the system that you claim every  
21 defendant was required to implement. Do I have  
22 that right?

23 MR. ELSNER: Objection; asked and answered.

24 A Yes, sir.

25 BY MR. SWANSON:

1 Q And so my question is, where in the model act that  
2 you signed off on, is that express requirement, you  
3 now claim is a requirement, where is it included in  
4 the model act? That's my question.

5 MR. ELSNER: Objection. Objection; asked and  
6 answered, several times.

7 A If I can explain again, sir, you cannot separate in  
8 the practice of pharmacy, drug utilization review  
9 and appropriate dispensing and the utilization of  
10 dispensing data to identify patterns of diversion  
11 or red flags. They are all one end product that  
12 must be used together.

13 The practice act requires DUR, the practice  
14 act requires that the pharmacist must comply with  
15 all federal and state laws, and the practice act  
16 says there must be appropriate dispensing of those  
17 products. And that is, in its entirety, what forms  
18 the basis then for any system to utilize dispensing  
19 data so the pharmacist is aware of that when they  
20 are conducting DUR and other checks to make sure  
21 that the patient receives the right medication and  
22 the prescription is for a legitimate medical  
23 purpose.

24 BY MR. SWANSON:

25 Q When you were with the NABP, did you have any

1 knowledge or awareness of the dispensing systems  
2 that you were utilized by the retail chain  
3 pharmacies in this case?

4 MR. ELSNER: Objection.

5 A From the view of a state board of pharmacy or NABP,  
6 but not as a practicing pharmacy. In those  
7 systems, I had experience, again, within the  
8 Osco/Albertsons system as a system as a pharmacist.

9 BY MR. SWANSON:

10 Q Got it. I guess my question was, though, by  
11 virtual of your role at the NABP, did you ever go  
12 out to different pharmacies and look at their  
13 systems and comment on them or advise?

14 A No, sir.

15 Q Okay. I'm going to move on to "Corresponding  
16 Responsibility." You provided opinions in this  
17 case regarding pharmacists corresponding  
18 responsibility and we talked a bit about --

19 A Mr. Swanson? Excuse me. Are you -- am I done with  
20 the model act? Do I need this anymore?

21 Q Yes, you can set that aside for now.

22 A Thank you, sir.

23 Q Thank you.

24 A Sorry for the interruption.

25 Q That's all right.

1           You provided opinions in this case and have  
2           written in your report we talked a bit about the  
3           corresponding responsibility in Section 1306.04,  
4           right?

5       A     Yes, sir.

6       Q     One of the things we talked about yesterday was  
7           that the state boards of pharmacy, sometimes they  
8           will put out newsletters to provide guidance and  
9           education to the pharmacists who practice in their  
10          state, right?

11      A     Yes, sir.

12      Q     And Ohio is one of the states that did that, right?

13      A     Yes, sir.

14      Q     They would periodically write about topics that  
15           were important to pharmacists who were dispensing  
16           medications, including opioids, right?

17      A     Yes, sir.

18      Q     Sometimes they would write about issues like laws  
19           and regulations that dictate the practice of  
20           pharmacy, true?

21      A     Yes, sir.

22      Q     And we talked yesterday, while you were at the  
23           NABP, you were an editor of portions of those  
24           letters but not the entire letter, right?

25      A     Yes, sir.

1 Q Your role was to act as the editor of NABP content  
2 and for state-specific content that was the  
3 responsibility of whoever the lead person was for  
4 the state board of pharmacy, right?

5 A Yes, sir.

6 Q But it was important that those newsletters  
7 contained accurate information regarding the  
8 practice of pharmacy, right?

9 A The responsibility for the accuracy rested with the  
10 state, sir.

11 Q Or with you, if it was your content, right?

12 A Yes, sir.

13 Q Or the NABP's content, I should say?

14 A Yes, sir.

15 Q If you can open up the envelope that's marked  
16 WAG 08?

17 A Yes, sir.

18 MR. ELSNER: I'm going to get this out to  
19 everybody else. We're now on 17.

20 (Exhibit 17 was marked for identification.)

21 MR. ELSNER: Just for time sake, if it's okay  
22 with everybody, I'm not going to put it up on the  
23 screen, but I have distributed it.

24 BY MR. SWANSON:

25 Q Okay. The document you have in front of you is a

1 May 2011 newsletter from the Ohio state board of  
2 pharmacy, correct?

3 A Yes, sir.

4 Q And if you look at the second page, you can see  
5 that in the bottom right, you're identified as the  
6 national news editor and executive editor, right?

7 A Yes, sir.

8 Q Looking at the content of Exhibit 17, it's a  
9 relatively short newsletter, right?

10 A I don't know if this is the entire newsletter, sir.  
11 So I can't --

12 Q It might just be a portion?

13 A Yeah. The middle portion is missing and I don't  
14 know if this is the first or second page of the  
15 Ohio, so I can't comment if it's the short or not.

16 MR. ELSNER: I'm going to object to the  
17 completeness of the document. But you can  
18 continue.

19 MR. SWANSON: Okay. Thanks.

20 BY MR. SWANSON:

21 Q If you look at the first page, there's a section  
22 that reads: "Corresponding responsibility is  
23 needed more than ever." Right?

24 A Yes, sir.

25 Q And this section continues to the second page of



1 the document. So you at least have a complete  
2 iteration of the section on the corresponding  
3 responsibility. Do you agree with that?

4 MR. ELSNER: Objection. I think it -- I think  
5 what it shows is that the document was originally  
6 four pages and you're showing us the first page and  
7 the fourth page.

8 MR. SWANSON: Right. But Mr. Elsner, what I  
9 just said is, it's a complete iteration of that  
10 section and I asked if he agreed with that. So I  
11 appreciate the objection. But I'm just asking --

12 (Simultaneous conversation.)

13 MR. ELSNER: I just want the record to be  
14 clear. Go ahead. You can answer.

15 A Sure. This is not the format that I've seen the  
16 newsletter in. And I don't know for sure if it's  
17 complete. It appears to be complete, but I can't  
18 say for certain that it is.

19 BY MR. SWANSON:

20 Q Okay. It begins: "In last May's newsletter, the  
21 board mentioned that it is having a tremendous  
22 problem in Ohio with so-called pain clinics that  
23 are doing nothing but providing large amounts of  
24 controlled substances, particularly oxycodone and  
25 hydrocodone to people who have no legitimate

1 medical need for them."

2 Do you see that?

3 A Yes, sir.

4 Q And do you recall that was a problem in Ohio back  
5 in 2011?

6 A I recall it was a problem, yes, sir.

7 Q If you turn to the next page, then, it continues  
8 on, that second complete sentence on page 2:  
9 "Since most of the pharmacists in Ohio have taken  
10 their corresponding responsibility requirements  
11 seriously, the patients, quote/unquote, of these  
12 operations are having more and more problems  
13 finding a place to get the prescriptions filled.  
14 The board has had calls from pharmacies as far away  
15 as Virginia and South Carolina asking about the  
16 legitimacy of these prescriptions."

17 Did I read that correctly?

18 A Yes, sir.

19 Q And do you recall that, at the time, that the Ohio  
20 Board of Pharmacy was of the view that its  
21 pharmacists were practicing their corresponding  
22 responsibility and that was leading patients to  
23 leave the state to try to get their prescriptions  
24 filled?

25 MR. ELSNER: Objection.

1 A I don't recall that, sir.

2 BY MR. SWANSON:

3 Q But you agree that that was the view of the state  
4 board of pharmacy expressed in Exhibit 17, true?

5 MR. ELSNER: Objection.

6 A No, sir, I would ask for your indulgence to allow  
7 me to read the entire article, rather than just  
8 comment on individual sections, if there's time to  
9 do that, sir.

10 BY MR. SWANSON:

11 Q Well, there's probably not time to do that so --

12 MR. ELSNER: Objection.

13 MR. SWANSON: I will ask you to comment.

14 BY MR. ELSNER:

15 Q I understand your request. I will just ask if you  
16 are able to comment on some of the provisions, I'm  
17 going to ask you about that. How about that?

18 A Can I clarify and explain that, sir?

19 Q Sure.

20 A Yesterday it was represented to me that the  
21 definition of doctor shopping by the Ohio Board of  
22 Pharmacy was five or more prescribers. When I  
23 actually researched that last night in the Ohio  
24 practice act rules, it was only more than one  
25 prescriber. So I don't want to misrepresent or

1 take something as an assumption that turns out not  
2 to be correct today.

3 So I will comment to the best of my ability,  
4 but I cannot make assumptions or take  
5 misrepresented information again to give the wrong  
6 answer to you.

7 MR. SWANSON: Okay. Well, I'll move to strike  
8 that response. And I understand -- I understand  
9 that you can only comment to the extent you are  
10 able when I ask you these questions.

11 BY MR. SWANSON:

12 Q Here's the question I --

13 MR. ELSNER: Wait.

14 BY MR. SWANSON:

15 Q -- want to ask you.

16 MR. ELSNER: But Mr. Catizone, please take the  
17 time that you need to put whatever sentence he asks  
18 you about in the appropriate context, okay?

19 THE WITNESS: Yes.

20 MR. SWANSON: I agree with that. I agree with  
21 that.

22 BY MR. SWANSON:

23 Q I want to ask you in the second column on the  
24 second page. The second complete sentence begins  
25 with the word "please."

1 Do you see that?

2 A No, sir, I apologize. I don't see that.

3 Q You don't need to apologize.

4 Second column, second sentence.

5 A Yes, sir. I found that.

6 Q Okay. It says: "Please note that the pharmacist  
7 is the one held accountable for making that  
8 independent judgment, not the employer, supervisor,  
9 or fellow employee."

10 Do you see that?

11 A Yes, sir.

12 Q Do you recall that it was the Ohio state board of  
13 pharmacy's view that the corresponding  
14 responsibility rested with the pharmacist; the  
15 pharmacist was the one that was accountable for  
16 exercising that judgment, and not the employer,  
17 supervisor, or fellow employee?

18 MR. ELSNER: Objection.

19 A I don't recall that, sir.

20 BY MR. SWANSON:

21 Q Do you at least agree with me that the state board  
22 of pharmacy is telling the pharmacists that it  
23 sends out this newsletter to, that it's the  
24 pharmacist who has the corresponding  
25 responsibility, and not the employer, supervisor,

1 or fellow employee?

2 MR. ELSNER: Objection.

3 A Based on the context of the newsletter and other  
4 information I know about the Ohio Board of  
5 Pharmacy, the newsletter is directed to  
6 pharmacists, practicing pharmacists, and that's why  
7 the content may have referred to pharmacists. But  
8 I know that the Ohio Board of Pharmacy at the time  
9 that I was at NABP took action forth -- against  
10 pharmacies for violating or not complying with  
11 their corresponding responsibility. So I think  
12 this is part of the answer or part of the position  
13 of the Ohio Board of Pharmacy.

14 MR. ELSNER: I'm just going to lodge an  
15 objection. You haven't established that  
16 Mr. Catizone was involved in the writing of any of  
17 this. In fact, I think his testimony was that  
18 he --

19 MR. SWANSON: Mike, let's stop the speaking  
20 objections and the coaching of the witness. Okay.  
21 Your objection is on the record and it's noted.

22 MR. ELSNER: It's important context, not for  
23 the witness. The witness already testified that  
24 his section was in pages 2 and 3. I want the  
25 record to be clear because you seem to indicate --

1           seem to suggest that he actually wrote this, and  
2           it's not clear to me that he wrote it or even saw  
3           it. And I think you have to lay that foundation.

4           MR. SWANSON: There's been zero suggestion  
5           that he wrote this, Mike.

6           MR. ELSNER: I disagree. The implication was  
7           you started with his name on the last page of the  
8           document. So please continue. But I'm going to  
9           continue to object to the use of this document if  
10          you don't lay the proper foundation. You can  
11          continue.

12          BY MR. SWANSON:

13          Q     All right. So again, my only question on this is,  
14                 you said this is a document that went out to  
15                 pharmacists, correct?

16          A     Yes, sir.

17          Q     And the intent was to educate pharmacists on laws  
18                 and regulations among other things, correct?

19          A     Yes, sir.

20          Q     And what the Ohio state board of pharmacy told the  
21                 pharmacists that it sent this letter to is that  
22                 both Ohio laws and rules and federal laws and  
23                 regulations place a corresponding responsibility on  
24                 the pharmacist to make a judgment and hold the  
25                 pharmacist accountable for that judgment, right?

1       A       I can only comment to say that's what the  
2               newsletter says. I can't comment beyond that, sir.

3       Q       Fair enough. You can set that one aside.

4               If you look at page 78 of your report, I'm  
5               going to pivot to a new topic here, briefly.

6               Are you on page 78?

7       A       Yes, sir.

8       Q       Page 78 of your report, you fault Walgreens -- and  
9               I'll just read: "Even so, as late as 2017,  
10              Walgreens refused to allow 'blanketly' refusing to  
11              fill prescriptions from a prescriber as long as the  
12              prescriber had an active DEA number."

13              Do you see that?

14      A       Yes, sir.

15      Q       You say: "Instead, it, Walgreens insisted  
16              pharmacists evaluate each prescription on a  
17              'case-by-case basis.'" Right?

18      A       Yes, sir.

19      Q       And in your view, that was a fault of Walgreens.  
20              Walgreens was doing wrong by refusing to implement  
21              blanket refusals to fill, right?

22              MR. ELSNER: Objection.

23      A       Yes, sir.

24              BY MR. SWANSON:

25      Q       And does that opinion apply to other pharmacies as



1 well, that other pharmacies also should have had  
2 blanket refusal to fill policies?

3 A Based upon the information, if the physician was  
4 involved in writing and prescribing prescriptions  
5 for nonlegitimate purposes and the pharmacist  
6 suspected diversion. And then the diversion could  
7 or could not be confirmed, the answer would be yes,  
8 sir.

9 Q Now, Walgreens policy was to ask their pharmacists  
10 to exercise their own independent judgment on a  
11 case-by-case basis, right?

12 A Yes, sir.

13 Q But it's your opinion that a pharmacy should  
14 mandate that its pharmacists refuse to fill  
15 prescriptions written by some doctors, even though  
16 those doctors still have an active DEA number,  
17 right?

18 A Based upon information that the pharmacist would  
19 have about that prescriber, yes, sir.

20 Q Do blanket refusal to fill policies like the one  
21 you advocate, do they interfere with the  
22 pharmacist's independent professional judgment?

23 A No, sir.

24 Q When I asked you yesterday what the independent  
25 professional judgment meant, you said that: "The

1 pharmacist is supposed to make an objective  
2 decision and not be influenced by any other factors  
3 such as corporate metrics or corporate  
4 requirements."

5 Do you remember giving that testimony?

6 A Yes, sir.

7 Q Doesn't the -- doesn't a blanket refusal to fill  
8 take away the pharmacist's ability to exercise  
9 independent judgment because it's based on a  
10 corporate requirement?

11 A No, sir.

12 MR. ELSNER: Objection.

13 BY MR. SWANSON:

14 Q Why not?

15 A The blanket refusal would be an independent  
16 judgment made by the pharmacist at the store. What  
17 is occurring with these policies is that the  
18 pharmacists from Walgreens in documents that I've  
19 looked at have asked to have certain prescribers  
20 put on a prescriber list so that prescriptions  
21 would not be filled by those prescribers and that  
22 was refused, and the policy back said, we must take  
23 these on a case-by-case basis.

24 If the pharmacist's independent judgment has  
25 determined that the prescriber is diverting

1 medication to not writing medications for  
2 legitimate medical purposes, then the pharmacist  
3 should make the independent judgment that they are  
4 not going to fill prescriptions for that prescriber  
5 for a controlled substance.

6 And I say that also based on my experience as  
7 a pharmacist, when a physician exhibited this type  
8 of behavior, we reported him to the state board of  
9 pharmacy, and I personally refused to fill any  
10 prescriptions for that doctor for controlled  
11 substances until the DEA or board of pharmacy had  
12 investigated that prescriber or medical board and  
13 provided back to me clearance that the pattern and  
14 actions were correct.

15 Q Have you seen evidence in this case of Walgreens'  
16 refusal to fill files?

17 A Yes, sir, I have.

18 Q And you didn't cite those in your report. Did you  
19 actually review them?

20 A Yes, I did cite them in my report, sir.

21 Q Okay. So you have seen evidence of Walgreens  
22 pharmacy -- pharmacists using their independent  
23 judgment to refuse to fill prescriptions that they  
24 felt were suspicious or illegitimate? You've seen  
25 that, right?

1 MR. ELSNER: Objection.

2 A So I clarify, sir, I looked at the good faith  
3 dispensing checklist that each Walgreens  
4 pharmacist -- and on there I thought there was  
5 refusal to dispense. If that's not the document,  
6 then I'm not sure exactly what you're referring to  
7 or if I reviewed that document.

8 BY MR. SWANSON:

9 Q Was it your view while you were at the NABP that  
10 blanket refusal to fill policies improperly  
11 interfered with the pharmacist's independent  
12 professional judgment?

13 MR. ELSNER: Objection.

14 A No, sir.

15 BY MR. SWANSON:

16 Q At the NABP, did you advocate that pharmacy stores  
17 should implement blanket refusals to fill for  
18 prescribers?

19 MR. ELSNER: Objection.

20 A I advocated that the pharmacists should use  
21 independent judgment and if they determined that,  
22 then they had all the writing authority to  
23 blanketly refuse to fill a prescription from a  
24 prescriber, yes, sir.

25 BY MR. SWANSON:

1 Q Well, but you're talking about a pharmacist  
2 blanketly refusing to fill. I'm asking about a  
3 pharmacy mandating that its pharmacists refuse to  
4 fill for a prescriber.

5 Do you see the difference there?

6 A Yes, sir.

7 Q And certainly, a pharmacist could determine that he  
8 or she doesn't trust the prescription that he's  
9 seeing from a physician and be suspicious of those  
10 and not fill them.

11 My question is whether, at the NABP, you  
12 advocated that pharmacies should implement blanket  
13 refusal to fill policies to prevent all of their  
14 pharmacists from filling prescriptions from certain  
15 prescribers.

16 Is that something you advocated at NABP?

17 MR. ELSNER: Objection.

18 A Yes, sir. Because NABP and the DEA feel that the  
19 pharmacy, as well as the pharmacist, is the  
20 registrant and responsibility and also held a  
21 corresponding responsibility.

22 I advocated while at NABP that the pharmacy  
23 incorporation should have appropriate controls and  
24 empower the pharmacist to make those independent  
25 judgments and provide the tools and support for the

1 pharmacist to be able to do that in order to combat  
2 diversion. So the answer is yes.

3 BY MR. SWANSON:

4 Q But a blanket refusal to fill policy is not  
5 empowering a pharmacist to use independent  
6 judgment. It is taking away a pharmacist's  
7 independent judgment, correct?

8 MR. ELSNER: Objection.

9 A No, sir.

10 BY MR. SWANSON:

11 Q So if a pharmacy company tells its pharmacists, you  
12 cannot fill any prescriptions written by Dr. Smith,  
13 in your view, that's empowering the pharmacist to  
14 use his or her independent judgment when he gets a  
15 prescription from Dr. Smith?

16 MR. ELSNER: Objection.

17 A Yes, sir. And it goes back to your earlier  
18 question.

19 BY MR. SWANSON:

20 Q That's fine.

21 A They are using dispensing data by the corporation  
22 to make that determination with the pharmacist so  
23 the corporation that is assuming responsibility  
24 providing the tools to the pharmacist needed to  
25 make such a decision.

1 Q Okay. I'm going to introduce a new exhibit. I'm  
2 sorry that I'm rushing, but I'm -- time is tight.

3 If you can open up WAG 23.

4 (Exhibit 18 was marked for identification.)

5 A Excuse me, Mr. Swanson?

6 Q Yes.

7 THE WITNESS: I think Ms. Fumerton has her  
8 hand raised. I don't know if she's trying to get  
9 someone's attention, so she's blocking my screen  
10 and I can't see and so...

11 MR. SWANSON: She may well be.

12 MS. FUMERTON: Am I on video? Please tell me  
13 I'm not. Actually, you know what? Brian, could  
14 we -- I'm sorry, I did not mean to do that. But  
15 Brian, could we just take a quick break? I'm  
16 sorry. I know it's not an hour. Just about five  
17 minutes?

18 THE WITNESS: Fine with me.

19 MR. ELSNER: We haven't gone an hour but  
20 what's the reason for the break? The witness is  
21 available.

22 MS. FUMERTON: Just a quick break. We have  
23 been going about an hour.

24 MR. ELSNER: It hasn't been an hour.

25 MR. SWANSON: Well, here, let me do --

1 SPECIAL MASTER COHEN: If someone needs a  
2 break, we ought to take a break.

3 MR. SWANSON: Okay.

4 THE VIDEOGRAPHER: We are going off the record  
5 at 8:59 a.m.

6 (A recess was taken.)

7 THE VIDEOGRAPHER: This is the Media Number 2  
8 in the deposition of Carmen Catizone. Today is  
9 June 16th, 2021. We're going to back on the record  
10 at 9:07 a.m.

11 BY MR. SWANSON:

12 Q Mr. Catizone, I have marked as Exhibit 18 a  
13 document. It has an email cover dated March 10,  
14 2015, an email to the stakeholder member  
15 organizations from you, and then it attaches the  
16 document that I want to talk about, which is the  
17 "Stakeholders Challenges and Red Flag Warning Signs  
18 Related to Prescribing and Dispensing Controlled  
19 Substances."

20 Is that the document that you have in front of  
21 you, sir?

22 A Yes.

23 Q This is a document that you've cited throughout  
24 your report in this case, correct?

25 A Yes, sir.



1 Q You've relied on this document, among others, to  
2 support your analysis of red flags in this case,  
3 right?

4 A Yes, sir.

5 Q This document was created -- Exhibit 18 was created  
6 while you were the executive director at NABP,  
7 right?

8 A Yes, sir.

9 Q You sat on a panel or a committee that met to  
10 discuss the contents of this document, true?

11 MR. ELSNER: Objection.

12 A It was not a formal committee, sir. It was just a  
13 stakeholder group or coalition.

14 BY MR. SWANSON:

15 Q Okay. Call it coalition, committee panel, whatever  
16 you want. It was a group of folks that got  
17 together to create the content of this document,  
18 right?

19 A Yes, sir.

20 Q Those groups or entities are listed on the  
21 beginning page of the actual stakeholder document,  
22 right? It starts with the American Academy of  
23 Family Physicians?

24 A Yes, sir.

25 Q And the entities that are listed on that

1 page ending in 240, those were the entities that  
2 participated in the creation of this red flag  
3 warning signs document, right?

4 A Yes, sir.

5 Q Were you the principal drafter?

6 A I was the executive editor, so to speak, sir.

7 Q Did you sort of have responsibility for the final  
8 content of the document?

9 MR. ELSNER: Objection.

10 A My responsibility was to coordinate all of the  
11 content and pull it all together, sir.

12 BY MR. SWANSON:

13 Q And do you stand behind the content of the  
14 document, Exhibit 18?

15 MR. ELSNER: Objection.

16 A Yes, sir, but the individual content areas were the  
17 responsibility of the various stakeholders. I did  
18 not have control over that, simply to make sure  
19 that the document fit together as a cohesive  
20 document, sir.

21 BY MR. SWANSON:

22 Q Right. But the document went out with your  
23 support, right?

24 A Yes, sir.

25 Q Do you believe that the document, Exhibit 18, was

1 an important tool for helping pharmacists to detect  
2 possible diversion?

3 MR. ELSNER: Objection.

4 A Not exactly, sir.

5 BY MR. SWANSON:

6 Q Okay. What was the purpose of this document?

7 A The purpose of this document was to foster  
8 communication between the stakeholders about red  
9 flags and the challenges that each of those groups  
10 faced so that the other groups would have a better  
11 understanding of what their responsibilities were  
12 and why pharmacists/prescribers were reacting and  
13 doing the things that they did.

14 Q One of the things that the stakeholders document  
15 does is identify possible red flags of diversion,  
16 right?

17 A Yes, sir.

18 Q Why was it necessary for the NABP to create a  
19 document describing possible red flags of  
20 diversion? Why not just rely on the DEA's  
21 definition of red flags?

22 MR. ELSNER: Objection.

23 A So back to the purpose of the meaning of the  
24 document. There were problems between prescribers  
25 and pharmacists regarding red flags and

1           corresponding responsibility. And so the red flags  
2           were used as discussion points between the groups  
3           to identify areas where there had been challenges  
4           and where physicians didn't understand why  
5           pharmacists and pharmacies had corresponding  
6           responsibility and why pharmacists were doing the  
7           things they did.

8           BY MR. SWANSON:

9           Q     What complaints did the physicians have about  
10           pharmacists corresponding responsibility?

11          A     Just before the organization of the stakeholders  
12           document, at the AMA annual meeting, one of the  
13           regional AMAs passed a resolution and the  
14           resolution said that pharmacists should simply fill  
15           prescriptions from the doctors and that pharmacists  
16           should provide no check or no second-guessing of  
17           those prescriptions, and that the pharmacists were  
18           interfering with the practice of medicine by  
19           exercising their responsibilities and prospective  
20           drug utilization review.

21                The particular issue was between Walgreens and  
22           the AMA. And we were approached by Walgreens and  
23           the AMA to convene a meeting of the stakeholders to  
24           try and resolve that communication issue, because  
25           pharmacists were conducting DUR questioning

1 patients and questioning prescribers in accordance  
2 with the corresponding responsibility.

3 Q So if I -- let me break that down a bit. You were  
4 approached by Walgreens and the AMA to convene this  
5 group of stakeholders?

6 A Yes, sir.

7 Q And who was it from Walgreens?

8 A I remember the individual from the AMA was one of  
9 their attorneys. And I think there were several  
10 people at Walgreens, but I can't remember  
11 specifically who it was.

12 Q And you said the circumstances where the AMA had  
13 passed a resolution asking, in essence, that the  
14 pharmacists stop challenging their prescribing  
15 decisions and just dispense medications that they  
16 prescribed. Is that a fair assessment?

17 A The second part is, sir. The physicians said that  
18 pharmacists should just dispense any prescription  
19 that's written.

20 Q And the folks at Walgreens had a problem with that  
21 because they had been calling the physicians to  
22 check on a prescription or to confirm that the  
23 prescription was appropriate, and that was  
24 upsetting the doctors, right?

25 MR. ELSNER: Objection.

1       A     It was part of the problem.  Some of the  
2             pharmacists were calling and asking for x-rays,  
3             MRIs, and other information that the physicians  
4             felt extended way beyond what the pharmacist's  
5             responsibility was.

6       BY MR. SWANSON:

7       Q     Okay.  So the folks at the AMA thought that the  
8             Walgreens pharmacists were doing too much inquiry  
9             into the doctor's practice; is that fair?

10       MR. ELSNER:  Objection.

11       A     Yes, sir.

12       BY MR. SWANSON:

13       Q     And the folks at Walgreens wanted guidance on what  
14             they should be doing so that they could still meet  
15             their corresponding responsibility in dispensing  
16             medications, right?

17       A     The purpose was that NABP would serve as an  
18             objective third party and open the lines of  
19             communication so that physicians and AMA would  
20             understand what pharmacists needed to do.  And then  
21             pharmacists then wouldn't encroach beyond what the  
22             responsibilities were into the practice of medicine  
23             as well.

24       Q     Does the stakeholders challenges and red flags  
25             warning signs document appropriately strike the

1 balance in your view as between a pharmacist's  
2 obligation and a doctor's obligations?

3 MR. ELSNER: Objection.

4 A To the extent that the individual red flags that  
5 were discussed, yes, sir.

6 BY MR. SWANSON:

7 Q Now, in the stakeholders document at page 10, you  
8 can see there's a Section 3 that discusses red  
9 flags. I'll give you a second to get there.

10 A I'm there, sir.

11 Q Okay. So Section 3 is the red flags section of the  
12 stakeholders document, correct?

13 A Yes, sir.

14 Q The section then breaks out, you know, what are red  
15 flags to prescribers and what might be red flags to  
16 pharmacists, right?

17 MR. ELSNER: Objection.

18 A Yes, sir.

19 BY MR. SWANSON:

20 Q And if you want to see what the red flags are for  
21 the pharmacists, you would turn to page 14 and  
22 you'd see what was identified by the group as  
23 pharmacy red flags, right?

24 MR. ELSNER: Objection.

25 A Some of the red flags, sir, yes.

1 BY MR. SWANSON:

2 Q What do you mean by some of the red flags?

3 A The document does not include all of the red flags  
4 that a pharmacist may encounter. It was again, red  
5 flags that the group, the stakeholders, wanted to  
6 have more discussion around.

7 Q Are you saying that the red flags that are  
8 identified on page 14 are the red flags that the  
9 stakeholders wanted to have more discussion around?  
10 Is that -- did I understand that correctly?

11 A Yes, sir.

12 Q And you're saying that there are additional red  
13 flags that aren't included here?

14 A Yes, sir.

15 Q And I was going to ask you about that because  
16 these -- the red flags that are identified in -- on  
17 page 14 don't match up exactly with the red flags  
18 that you've identified in your report. Do you  
19 agree with that?

20 A Yes, sir.

21 Q Would you agree with me that reasonable minds can  
22 differ as to what constitutes a red flag to a  
23 pharmacist?

24 MR. ELSNER: Objection.

25 A No, sir.



1 BY MR. SWANSON:

2 Q So when you say that it's a red flag if a patient  
3 travels more than 25 miles to see his or her  
4 prescriber, you're saying if somebody said I  
5 think it's more reasonable to be -- to set it at  
6 35 miles, you'd say no, reasonable minds can't  
7 disagree about this, it's 25 miles?

8 MR. ELSNER: Objection.

9 A The question as you've posed it, the DEA in their  
10 guidance in other documents have pointed out  
11 specific red flags. So distance is a red flag.  
12 25 miles is a parameter that, as I've determined,  
13 is a safe parameter to utilize. So a pharmacist  
14 may, in their professional and independent  
15 judgment, make a determination that 30 miles or  
16 20 miles may not be a red flag. But it's still a  
17 red flag for them to conduct further due diligence.

18 The red flags the DEA have identified, those  
19 are not things that are discussed or debatable.  
20 They are actually standards of care in that  
21 highway.

22 BY MR. SWANSON:

23 Q But my question was a bit more basic. Can  
24 reasonable minds differ as to what constitutes a  
25 red flag?

1 MR. ELSNER: Objection.

2 A Out of the 16 red flags I have identified in my  
3 report, my answer is no, sir.

4 BY MR. SWANSON:

5 Q That reasonable minds could not differ? Those 16  
6 red flags are required, no ifs, ands, or buts; is  
7 that your testimony?

8 MR. ELSNER: Objection.

9 A Yes, sir.

10 BY MR. SWANSON:

11 Q If you look -- so you have on page 14, it  
12 identifies -- I don't know the number, but it  
13 identifies the red flags that the panel wanted to  
14 discuss, right?

15 A Yes, sir.

16 Q Then in section 4, there's a section that's called,  
17 "Other aberrant medication-related behaviors and  
18 factors potentially indicative of substance abuse  
19 or diversion," right?

20 A Yes, sir.

21 Q And again, it breaks out between physicians and  
22 pharmacists about what might constitute other  
23 aberrant behavior, right?

24 A Yes, sir.

25 Q On page 16, if you go to the section on

1           pharmacists, I want to ask you about that. Are you  
2           there?

3           A     Yes, sir.

4           Q     The second sentence in that paragraph reads:  
5                 "While the above factors or "red flags" are more  
6                 indicative of substance abuse or diversion,  
7                 oftentimes, more subtle aberrant behaviors exist  
8                 that, while in and of themselves may not be  
9                 problematic, may indicate a potential issue that  
10                warrants further evaluation prior to dispensing."

11                Do you see that?

12                THE REPORTER: We've lost the witness.

13                MR. ELSNER: Sorry. We had a power surge.

14                THE VIDEOGRAPHER: We are going off the record  
15                at 9:20 a.m.

16                (A recess was taken.)

17                THE VIDEOGRAPHER: We're going back on the  
18                record at 9:21 a.m.

19           BY MR. SWANSON:

20           Q     Mr. Catizone, I'm not sure where I cut out. So why  
21                 don't I read my last question back and we'll start  
22                 there, okay?

23           A     Thank you.

24           Q     Okay. I've directed you to page 16 of the  
25                 stakeholders document, the section regarding

1 pharmacists, right?

2 A Page 15 is prescribers.

3 Q 16.

4 A Oh, 16, sorry. Okay.

5 MR. ELSNER: The second sentence  
6 under "Pharmacists."

7 BY MR. SWANSON:

8 Q Correct. It reads: "While the above factors or  
9 'red flags' are more indicative of substance abuse  
10 or diversion, oftentimes more subtle aberrant  
11 behaviors exist that, while in and of themselves  
12 may not be problematic, may indicate a potential  
13 issue that warrants further evaluation prior to  
14 dispensing."

15 Did I read that correctly?

16 A Yes, sir.

17 Q And then it goes on to describe some of these --  
18 what you and the stakeholders termed aberrant  
19 behaviors, right?

20 A The pharmacist stakeholders did, sir.

21 Q Well, so what's your responsibility for this  
22 document? I mean, is this something that you say,  
23 well, there are a bunch of stakeholders but they  
24 only take ownership for their specific sections?

25 MR. ELSNER: Objection.

1       A     What happened, sir, was each group was asked to  
2             write their individual sections. So prescribers  
3             were asked as to what they viewed red flags, what  
4             the challenges they faced with patients, same with  
5             the pharmacists group. So the American Pharmacy  
6             Association, Walgreens, all the participants that  
7             were pharmacies and pharmacists put together this  
8             section.

9             My role was to ensure that there was nothing  
10            offensive in there that criticized or aggravated  
11            the other stakeholders. But this is what the  
12            pharmacy groups felt was happening in pharmacy  
13            practice in their interactions with prescribers  
14            that was important for prescribers to know.

15       BY MR. SWANSON:

16       Q     But it's a document that you supported, right, you  
17             supported the stakeholders document in its final  
18             form, right?

19       A     Yes, sir.

20       Q     Okay. And if you objected to positions or language  
21             that was included in this stakeholder document, you  
22             didn't have to sign off on it, right? You could  
23             have said, I'm not going to be a party to this, you  
24             had that opportunity if you needed it, right?

25       A     Yes, sir, I thought the question was whether or not

1 I agreed with this. And my role was not to agree  
2 with it. It was to make sure that the document met  
3 its purpose, which was open the lines of  
4 communication.

5 Q Okay. But in any event, you were -- it was  
6 acceptable to you that the document went out with  
7 you as a signatory, so to speak, and was published  
8 with your name on it, right?

9 A Yes, sir.

10 Q And the section on aberrant behaviors for  
11 pharmacists, it says: "Aberrant behaviors that  
12 patients may exhibit upon the presentation of the  
13 prescription include traveling unexplainable and/or  
14 unreasonably long distance to a physician office  
15 and/or the pharmacy, or requesting to pay cash for  
16 a controlled substance prescription when it has  
17 been documented that he or she has insurance that  
18 would normally cover the prescription."

19 Right?

20 A Yes, sir.

21 Q And in your view, those are -- at least your view  
22 in this case, in this litigation, is that -- those  
23 two behaviors, traveling long distances and paying  
24 cash, they are red flags that nobody could disagree  
25 with? They're just -- they're red flags, right?

1 A Yes, sir.

2 Q In the document that you signed off on, the  
3 stakeholders document said no, no, no, those aren't  
4 red flags, they are behaviors that might warrant  
5 suspicion, but they might have easily explainable  
6 answers, right?

7 MR. ELSNER: Objection.

8 A No, sir.

9 BY MR. SWANSON:

10 Q Well, it says: "Whereas, these types of behaviors  
11 may be warning signs, they can also be explained by  
12 today's specialty practice arena as well as  
13 third-party payor reimbursement circumstances."  
14 Right?

15 A That's what it says.

16 Q Okay. And this wasn't something that you objected  
17 to such that you refused to put your name on this  
18 document, right?

19 A What the document -- what it says, that I signed  
20 off on, sir, was that these may be aberrant  
21 behaviors as well as red flags. But the document  
22 also says that both types of situations result in  
23 diversion. And also if you read in there, an  
24 important point that you and I have been discussing  
25 all morning, it says "whereas, documented." That

1           once again is the importance of documentation that  
2           is documented if a person has insurance, the  
3           documentation about that patient decides whether or  
4           not the red flag that's been identified is  
5           legitimate or not.

6           So documentation is critical to this entire  
7           process, as the document was constructed, my  
8           interpretation and my sign-off of that document,  
9           sir.

10        Q     Well, sir, respectfully, what it says is, when it  
11           has been documented that he or she has insurance.  
12           That's the documentation it's talking about, right?

13           MR. ELSNER:  Objection.

14        A     No, the documentation included the prescription  
15           process which would include that as part of the  
16           process.  I was there for the document, sir, and  
17           that was how it was presented and understood.

18        BY MR. SWANSON:

19        Q     Okay.  Well, what it says, all right, so the people  
20           who weren't there who were just getting this out in  
21           the public, it says:  "Requesting to pay cash for a  
22           controlled substance prescription when it has been  
23           documented that he or she has insurance, that would  
24           normally cover the prescription."  That's what the  
25           document reads, correct, "yes" or "no"?



1 MR. ELSNER: Objection.

2 A Yes. Pharmacists would know what that means.

3 BY MR. SWANSON:

4 Q Yes. And you don't claim that any of the  
5 defendants in this case didn't document whether the  
6 patient who came in had insurance or not? That's  
7 not a claim you're making, is it?

8 MR. ELSNER: Objection.

9 A I'm not understanding the question. I'm sorry,  
10 sir.

11 BY MR. SWANSON:

12 Q You're not saying that the retail pharmacies in  
13 this case didn't have documentation about whether  
14 the patient had insurance, right?

15 A I'm claiming that the defendants in this case  
16 should have documented the prescription process  
17 which included whether they had insurance coverage  
18 or not.

19 Q Now, I was going to ask you whether it said  
20 anywhere in this document that the pharmacist was  
21 required to document resolution of red flags. And  
22 I thought you were going to say no, but I guess  
23 because the word document has appeared in that  
24 paragraph, you're going to say that this document  
25 does say that pharmacists must document resolution

1 of red flags; is that right?

2 A Yes, sir.

3 Q Okay. So if I asked you the question, where in  
4 this document does it tell me and tell pharmacists  
5 that they're required to document the resolution of  
6 red flags, you would point me to that sentence that  
7 I just read?

8 MR. ELSNER: Objection.

9 A I would point you to that paragraph, sir, which  
10 says, here is a behavior. It is a red flag. It  
11 could also be an aberrant behavior, and here's the  
12 resolution of that behavior by a pharmacist, which  
13 was determining whether or not distance was a  
14 probable explanation and that was documented.

15 So that paragraph in its entirety and as part  
16 of the document is exactly the basis for the  
17 requirement for documentation, sir.

18 BY MR. SWANSON:

19 Q Got it.

20 Okay. I'm about done. I'd like you to turn  
21 to page 4 of your report.

22 A Yes, sir.

23 Q Okay. Page 4 is a continuation of the summary of  
24 your opinions in this case, right?

25 A Yes, sir.

1 Q And I want to ask you about the last bullet, the  
2 last summary opinion that you provide here.

3 You say that: "The defendants failed to  
4 provide their pharmacists with data, information,  
5 and the tools necessary to assist their pharmacists  
6 in fulfilling their corresponding responsibility,  
7 duties, including but not limited to, utilizing  
8 dispensing data to identify patterns, trends, and  
9 practitioners possibly involved in diversion, as  
10 well, to recognize and resolve red flags."

11 Do you see that?

12 A Yes, sir.

13 Q Is it your opinion in this case that pharmacists  
14 cannot fill their corresponding responsibility  
15 without the systems that you claim the retail chain  
16 pharmacy should have implemented?

17 A Those systems are needed to assist the pharmacists,  
18 sir.

19 Q Well, my question was different.

20 Is it your opinion that pharmacists cannot  
21 fulfill their corresponding responsibility without  
22 the systems that you claim the retail chains should  
23 have implemented?

24 MR. ELSNER: Objection.

25 A If pharmacists do not have the access to

1 information about the patient prescriber they need  
2 to fill that prescription, my answer is yes.

3 BY MR. SWANSON:

4 Q Okay. But I want to be clear on this, because you  
5 say that there were very specific systems that had  
6 to be implemented by the retail chain pharmacies  
7 and specific ways to use the dispensing data.  
8 That's your opinion, right?

9 MR. ELSNER: Objection.

10 A I refer to them as tools, sir, not -- and I didn't  
11 specify what they should be. But they should be  
12 tools available to the pharmacists.

13 BY MR. SWANSON:

14 Q And in your opinion, those tools include --  
15 necessarily must include using dispensing data  
16 making the dispensing data available to the  
17 pharmacist to detect possible patterns of  
18 diversion, that's your opinion, right?

19 A Yes, sir.

20 Q So my question is, is it your opinion that  
21 pharmacists cannot fulfill their corresponding  
22 responsibility without that tool, that specific  
23 tool, that you claim the retail chains should have  
24 implemented?

25 MR. ELSNER: Objection.

1       A     Yes, sir. As an individual pharmacist, they have  
2           the dispensing data available to them to make that  
3           decision. In a corporation like Walgreens, that  
4           dispensing data rests with the corporation. And if  
5           the corporation doesn't provide that data to the  
6           pharmacist, the pharmacist doesn't have the  
7           complete information to make that decision.

8           MR. SWANSON: Okay. Move to strike as  
9           nonresponsive.

10          MR. ELSNER: Objection.

11          BY MR. SWANSON:

12       Q     Is it your opinion that pharmacists cannot fulfill  
13           their corresponding responsibility without the  
14           specific tool that you just discussed that you  
15           claim the retail chain pharmacies should have  
16           implemented?

17          MR. ELSNER: Objection; asked and answered.

18       A     Without dispensing data on controlled substances  
19           and red flags, my answer is yes, sir.

20          BY MR. SWANSON:

21       Q     And you've identified of all the pharmacies in the  
22           country, one pharmacy that has -- that you say has  
23           such a system, right?

24       A     No, sir.

25          MR. ELSNER: Objection.

1 BY MR. SWANSON:

2 Q What other pharmacies other than Albertsons have  
3 you identified?

4 MR. ELSNER: Objection.

5 A You asked me to give one example. I gave you one  
6 example, and then said I could not identify other  
7 individual pharmacies without being able to go  
8 through and question and look at all the different  
9 pharmacy systems. So my answer is -- my answer  
10 was, there were more pharmacies, but I could not  
11 identify those beyond Albertsons.

12 BY MR. SWANSON:

13 Q The second sentence, you say: "The subsequent  
14 result of the failure to provide such data,  
15 information, and tools was the diversion of  
16 significant quantities of controlled substances,  
17 particularly opioids, outside of the closed  
18 distribution and dispensing system for controlled  
19 substances."

20 Right?

21 A Yes, sir.

22 Q Now, in your report, you've identified, and we've  
23 talked a lot about 16 different red flags, right?

24 A Yes, sir.

25 Q And those red flags have been run by Dr. McCann

1 across some subset of each pharmacy's dispensing  
2 data, right?

3 A Yes, sir.

4 Q And the result is that in your report, you've  
5 identified, for each red flag, a certain number of  
6 prescriptions, right?

7 A Dr. McCann identified, sir.

8 Q Okay. And then you put those into your report,  
9 right?

10 A Yes, sir.

11 Q So if you turn, please, to page 33, I just want to  
12 ask you about one of these and then we'll finish  
13 up.

14 A I'm there, sir.

15 Q Okay. On page 33, I want to look at your red flag  
16 Number 2, okay?

17 A "Prescriber Distance," sir?

18 Q Yes. So there, you've said it's a red flag if a  
19 patient traveled more than 25 miles to visit their  
20 prescriber, right?

21 A Yes, sir.

22 Q For Walgreens, you identified 37,066 prescriptions  
23 that fit that red flag in some subset of dispensing  
24 data between 2006 and 2020, right?

25 A Again, just to clarify, Dr. McCann identified those

1           prescriptions. That was included in my report,  
2           yes.

3           Q     And to be clear here, you did not look at any  
4                 individual prescription in that set, 37,066  
5                 prescriptions, to test your opinion as to whether  
6                 that was actually -- any one was actually a  
7                 suspicious prescription, right?

8           A     Correct, sir.

9           Q     So you can't tell me that any of the doctors who  
10                wrote any one of those 37,066 prescriptions, right?

11                MR. ELSNER: Objection.

12           A     I'm sorry, sir. I didn't understand what the  
13                question was.

14           BY MR. SWANSON:

15           Q     You can't identify any doctor who wrote any of  
16                those 37,066 prescriptions, right?

17                MR. ELSNER: Objection.

18           A     Correct, sir.

19           BY MR. SWANSON:

20           Q     But those 37,066 prescriptions, they might have  
21                been written oncologists at the Cleveland Clinic.  
22                You just don't know one way or the other, right?

23                MR. ELSNER: Objection.

24           A     I did not review the individual prescriptions, just  
25                aggregate data, sir.



1 BY MR. SWANSON:

2 Q And because you didn't look at any individual  
3 prescription, you can't say if any diligence was  
4 conducted on any of those prescriptions, right?  
5 You just don't know?

6 MR. ELSNER: Objection.

7 A Partially, sir. If the documentation was included  
8 on patient notes, I would have been able to  
9 determine that without seeing the individual  
10 prescription, but I didn't have that information  
11 available either.

12 BY MR. SWANSON:

13 Q But you didn't look at any prescriptions? So you  
14 can't say whether a red flag was cleared or wasn't  
15 cleared by the pharmacist, right? Again, you just  
16 don't know because you're relying on aggregate  
17 data, right?

18 MR. ELSNER: Objection. Objection;  
19 mischaracterizes his testimony.

20 A We used the aggregate data. What was missing for  
21 me to substantiate that was the documentation in  
22 notes that the pharmacist should have included to  
23 resolve that red flag.

24 BY MR. SWANSON:

25 Q Okay. Whether it was missing or not, you just

1 don't know one way or the other whether a  
2 pharmacist cleared and documented any of those  
3 37,066 prescriptions, right? You just don't know?

4 MR. ELSNER: Objection.

5 A Correct.

6 BY MR. SWANSON:

7 Q And you can't say -- because of that, you can't say  
8 whether any of those 37,066 prescriptions were  
9 written for an illegitimate reason, right?

10 A No, sir.

11 Q Well, if you didn't look at the prescription, and  
12 you don't know who the doctor was writing it, and  
13 you don't know the circumstances of the  
14 prescription, how can you say that any one of those  
15 37,066 prescriptions was written for an  
16 illegitimate reason?

17 MR. ELSNER: Objection.

18 A Based on information I provided earlier. Based on  
19 the amount of opioids that were dispensed in those  
20 two counties. Based upon the amount of deaths per  
21 hundred thousand people in those two counties. And  
22 based on the fact that still 37,000 prescriptions  
23 tagged for that red flag indicates to me from an  
24 aggregate data and overall view that diversion  
25 occurred and diversion occurred at a significant

1 level; even though I can't identify which specific  
2 prescriptions were diverted.

3 BY MR. SWANSON:

4 Q Okay. You can't tell me what individual  
5 prescriptions were, in your view, illegitimate.  
6 What percentage of those 37,066 prescriptions were  
7 written for an illegitimate reason?

8 MR. ELSNER: Objection.

9 A The best way I can qualify that and give you an  
10 answer, sir, is a significant number based upon the  
11 total of opioids that were dispensed and based on  
12 the resulting deaths in overdoses. Beyond that, I  
13 can't give you anything more than "significant" and  
14 I can't qualify it beyond "significant."

15 BY MR. SWANSON:

16 Q So you can't tell me if it's 10 percent or  
17 20 percent or 30 percent, you can't tell me that,  
18 can you, sir?

19 A I can if you provide the documentation that whether  
20 or not those red flags were resolved. That would  
21 allow me to give you the percentage versus the  
22 aggregate totals, the deaths, and the supply of  
23 opioids in those two counties.

24 Q But I have you in front of me today for  
25 questioning. So sitting there in your chair today,

1           you can't tell me what percentage of those 37,066  
2           prescriptions you claimed were written for an  
3           illegitimate reason, true?

4           MR. ELSNER: Objection.

5       A     My answer is significant and significant would be  
6           far greater than 10, 20, or 30 percent. Probably  
7           more in the range of between 70 and 80 or  
8           90 percent, sir.

9       BY MR. SWANSON:

10      Q     Oh, so your opinion -- your opinion is that 70 to  
11           90 percent of those 37,066 prescriptions were  
12           written for an illegitimate reason?

13      A     No, sir. You asked me to define just sitting in  
14           the chair today what I thought would be a  
15           significant number. And to me, a significant  
16           number is somewhere to 70, 80 percent. Again,  
17           lacking the documentation, I cannot quantify  
18           whether or not those 37,000 prescriptions fell into  
19           that category. But if you ask me what's the  
20           difference between significant and others, for me a  
21           significant number of prescriptions would be 70,  
22           80 percent if I could make that determination, sir.

23      Q     So a significant quantity of controlled substances  
24           at 70 to 80 percent to you?

25           MR. ELSNER: Objection.

1       A       A significant number versus not a significant  
2               number, sir.

3               BY MR. SWANSON:

4       Q       Okay. 70 to 80 percent is what you qualify as  
5               significant?

6       A       Yes, sir.

7               MR. ELSNER: Objection.

8               BY MR. SWANSON:

9       Q       So let's turn back to page 4. I want to read the  
10              second sentence of your opinion again.

11              "The subsequent result of the failure to  
12              provide such data, information, and tools was a  
13              diversion of significant quantities of controlled  
14              substances particularly opioids, outside of the  
15              closed distribution and dispensing system for  
16              controlled substances." Right?

17      A       Yes, sir.

18      Q       So if I understand your testimony, it is your view  
19              that 70 to 90 percent of the medications that were  
20              dispensed by the retail chain pharmacies were  
21              diverted outside of the closed distribution and  
22              dispensing system for controlled substances?

23              MR. ELSNER: Objection.

24              BY MR. SWANSON:

25      Q       Right?

1 A No, sir.

2 Q Okay. Where is my disconnect there?

3 A The disconnect is, I've said that a significant  
4 number of prescriptions were diverted outside of  
5 the system. But absent patient notes and other  
6 documentation, I couldn't qualify or quantify what  
7 significant meant. And defining significant as a  
8 general term, that term for me means between 70 and  
9 90 percent. If I had the documentation, I would be  
10 able then to make a determination beyond how many  
11 patients died in Lake and Trumbull County, and how  
12 many opiates were distributed per person in opiate  
13 [sic] county that, to me, supports "significant"  
14 and would help me quantify that beyond just the  
15 term "significant."

16 Q Sitting here today, can you do anything other than  
17 speculate as to what percentage of the 37,066  
18 prescriptions that hit on flag 2 for Walgreens were  
19 for an illegitimate medical purpose?

20 MR. ELSNER: Objection.

21 A Again, it's not a speculation, sir. It's based on  
22 the data, the number of opioids that were  
23 distributed in those counties, the number of  
24 overdoses and deaths indicate to me factually that  
25 there was a significant diversion of prescriptions.

1 BY MR. SWANSON:

2 Q And again, significant to you is 70 to 80 percent?

3 MR. ELSNER: Objection.

4 A As a general term, sir, yes.

5 BY MR. SWANSON:

6 Q I don't want to go through it all, but would your  
7 same answer apply if I asked you about any one of  
8 these numbers that you've included for any of the  
9 retail chain pharmacies in the red flag analysis?

10 MR. ELSNER: Objection.

11 A Significant in all of those cases, yes, sir.

12 MR. SWANSON: I appreciate your answering my  
13 questions. I think I'm short on time so I'm going  
14 to pass you off to one of my colleagues.

15 THE WITNESS: Thank you, sir.

16 MR. SWANSON: Thank you.

17 CROSS-EXAMINATION

18 QUESTIONS BY JOHN GISLESON:

19 Q Good morning, Mr. Catizone. My name is John  
20 Gisleson and I represent Rite Aid.

21 Have you been to either Lake County or  
22 Trumbull County?

23 A No, sir.

24 Q Do you know how many stores, pharmacy stores Rite  
25 Aid has in Lake County?

1 MR. ELSNER: Objection.

2 A I think approximately four or five, sir, but I'm  
3 not certain.

4 BY MR. GISLESON:

5 Q Do you know how many stores any of the other  
6 pharmacy defendants have in Lake County?

7 MR. ELSNER: Objection.

8 A Again, I've looked at that data, and I think they  
9 vary between three and five for the other  
10 defendants, Giant Eagle has the smallest number of  
11 pharmacies within those counties, sir.

12 BY MR. GISLESON:

13 Q Same questions for Trumbull County. Do you know  
14 how many pharmacy stores each of the chain  
15 defendants have in Trumbull County?

16 MR. ELSNER: Objection.

17 A I believe it's relatively the same proportion, sir,  
18 somewhere between three and five for the larger  
19 chains, and then maybe one or two for Giant Eagle.

20 BY MR. GISLESON:

21 Q As part of your investigation in this case, did you  
22 seek to determine what the specific geographic area  
23 serviced by each store in each county was?

24 A No, sir.

25 Q Would you expect the geographic area serviced by



1           each pharmacy store in Lake and Trumbull County to  
2           vary?

3                   MR. ELSNER:  Objection.

4       A     If you could help me understand what you mean by  
5           "vary," sir.

6       BY MR. GISLESON:

7       Q     Sure.  Would you expect that some stores -- strike  
8           that.

9                   Would you expect that some pharmacy stores in  
10           Lake and Trumbull Counties service a larger  
11           geographic area, whereas others might service a  
12           smaller geographic area?

13      A     Yes, sir.

14      Q     Did you do anything to investigate the specific  
15           geographic area serviced by each pharmacy store in  
16           Lake and Trumbull Counties?

17                   MR. ELSNER:  Objection.

18      A     No, sir.

19      BY MR. GISLESON:

20      Q     Did you do anything as part of your investigation  
21           in this case to determine how many patients were  
22           serviced by each chain pharmacy store in Lake and  
23           Trumbull County?

24                   MR. ELSNER:  Objection.

25      A     No, sir.

1 BY MR. GISLESON:

2 Q Would you expect that some chain pharmacy stores in  
3 Lake and Trumbull County have more patients than  
4 other stores?

5 A Yes, sir.

6 Q Did you do anything to evaluate the demographics of  
7 the patients served by each chain pharmacy store in  
8 Lake and Trumbull County?

9 A No, sir.

10 Q Do you agree that the patient demographics may vary  
11 from store to store, depending on the local  
12 community?

13 A I would agree the demographics would vary, but the  
14 opioid epidemic cuts across all demographic factors  
15 and affects equal -- the populations equally. So  
16 yes and no, sir.

17 Q As part of your analysis in this case, did you do a  
18 specific investigation of the dispensing practices  
19 of any particular pharmacy?

20 MR. ELSNER: Objection.

21 A Again, Mr. Gisleson, by dispensing practices, can  
22 you just help me understand what you mean by that?

23 BY MR. GISLESON:

24 Q Sure.

25 Did you evaluate the percentage of controlled

1           versus noncontrolled prescriptions dispensed by a  
2           particular pharmacy store in Lake or Trumbull  
3           County?

4           MR. ELSNER: Objection.

5       A     No, sir.

6       BY MR. GISLESON:

7       Q     Did you evaluate the prescribing -- strike that.

8           Did you evaluate the dispensing practices of  
9           any particular pharmacist in either Lake or  
10          Trumbull County?

11      A     No, sir.

12      Q     Did you review any patient medical records for any  
13           of the prescriptions that you flagged?

14      A     No, sir.

15      Q     Did you speak with any pharmacists in Ohio who  
16           worked for one of the chain pharmacy defendants?

17      A     No, sir, but I read the depositions of the  
18           pharmacists who practiced in Ohio and supervised  
19           pharmacists in Ohio.

20      Q     Did you speak with anyone from the Ohio board of  
21           pharmacy concerning dispensing practices in Lake or  
22           Trumbull County as part of the work you did in this  
23           case?

24      A     No, sir.

25      Q     During the time that you were preparing your report

1 in this case, did you know who ran the day-to-day  
2 operations of the Ohio board of pharmacy?

3 A Yes, sir.

4 Q What's the name of that individual?

5 A What division, sir? Steve Schierholt is the  
6 executive director and oversees the entire board.

7 The compliance officer, is that who you were  
8 asking about, sir?

9 Q Either.

10 Did you speak with either Mr. Schierholt or  
11 the compliance officer for the Ohio Board of  
12 Pharmacy as part of your work in this case?

13 A No, sir.

14 Q Did you request from the Ohio board of pharmacy any  
15 information as to the guidance the Ohio Board of  
16 Pharmacy provided to chain pharmacy stores in Ohio?

17 A No, sir.

18 Q Did you do any investigation as to the continuing  
19 education courses that were taken by the  
20 pharmacists who worked for the chain pharmacy  
21 defendants?

22 A No, sir.

23 Q What was the continuing education requirement for  
24 pharmacists in Ohio between 2006 and 2020?

25 MR. ELSNER: Objection.

1       A       That information is contained in NABP Survey of  
2               Pharmacy Law, which I did not access but I could  
3               access if needed.

4       BY MR. GISLESON:

5       Q       Can you describe what the Survey of Pharmacy Law  
6               is?

7               MR. ELSNER:  Objection.

8       A       Survey of Pharmacy Law is a compilation of state  
9               laws that the executive directors of the state  
10              boards of pharmacy put together.  Included in that  
11              section is the continuing education requirements of  
12              each individual states, and I do believe that Ohio  
13              requires some continuing education in pharmacy law,  
14              besides live and via workbook or webinar CE.

15      BY MR. GISLESON:

16      Q       When you say compilation of state laws, how are  
17               those laws compiled in that survey?

18      A       There are a series of charts that specify certain  
19               parts of the law or certain laws, and the state  
20               board executive director fills that out.  So for  
21               example, it would say, "is a license required for a  
22               pharmacy in your state?"  And the executive  
23               director would check yes or no.  That type of  
24               compilation, sir.

25      Q       Does the Survey of Pharmacy Law address the

1 requirements of the Controlled Substances Act?

2 A Some of those, sir, yes.

3 Q As part of your responsibilities as the executive  
4 director for the NABP, did you review the Survey of  
5 Pharmacy Law before it was issued?

6 A Yes, sir.

7 Q And did you approve the Survey of Pharmacy Law  
8 before it was issued?

9 MR. ELSNER: Objection.

10 A I did not approve the individual state content  
11 because that would be up to the states to determine  
12 if that was correct. I approved the format of that  
13 publication when it was released.

14 BY MR. GISLESON:

15 Q What was the frequency with which the Survey of  
16 Pharmacy Law was released by the NABP?

17 A It's updated annually, sir.

18 Q To whom did the NABP provide that survey of law?

19 A It's provided to all the state boards of pharmacy,  
20 all of the 140 colleges of pharmacy and it's  
21 provided to students as well, graduating students,  
22 and then any pharmacy, pharmacist, corporation, or  
23 individual that wants to purchase a copy is able to  
24 do so.

25 Q So that if any pharmacist is interested in knowing

1           what Ohio law requires of a pharmacist in  
2           connection with dispensing controlled substances,  
3           it would be appropriate for that pharmacist to read  
4           the Survey of Pharmacy Law for Ohio?

5       A     No.

6       Q     Why not?

7       A     What the pharmacist would have to read and be  
8           responsible for is the Ohio practice and rules.  
9           Ohio also has a requirement that pharmacists must  
10          maintain a written copy of the Ohio newsletter and  
11          the Ohio newsletter includes updates and  
12          information on laws in Ohio.

13               The Survey of Pharmacy Law would be a nice  
14          handy guide for pharmacists to better understand or  
15          easily access questions they may have about the law  
16          in Ohio.

17       Q     Did the Survey of Pharmacy Law at any point between  
18           2006 and 2020 specifically state for Ohio that  
19           pharmacy law requires a pharmacist to document the  
20           resolution of red flags?

21               MR. ELSNER:  Objection.

22       A     I don't recall that specific section, sir, in the  
23           Survey of Pharmacy Law.

24               BY MR. GISLESON:

25       Q     Can you identify any newsletter issued by the board

1 of Ohio that specifically stated that a pharmacist  
2 must document the resolution of red flags?

3 A I can't specifically, but I do remember that, as  
4 the executive editor and reviewing content at the  
5 states, that the Ohio Board of Pharmacy did issue  
6 newsletters that talks about the responsibility of  
7 the pharmacist as well as the pharmacy and did talk  
8 about red flags particularly after the Volkman  
9 decision in Ohio. I know there were newsletters  
10 from Ohio that talked about that. They talked  
11 about resolving and documenting red flags, sir.

12 Q If I want to get a complete set of the newsletters  
13 that were issued by the Ohio Board of Pharmacy to  
14 pharmacists and pharmacies in Ohio, how can I  
15 obtain that documentation?

16 MR. ELSNER: Objection.

17 A I think you --

18 BY MR. GISLESON:

19 Q I'll rephrase the question.

20 Do you know whether there was anybody in Ohio  
21 that compiles the newsletters that are issued by  
22 the Ohio Board of Pharmacy to pharmacists?

23 A Just as basic information? The source of that  
24 would be the Ohio Board of Pharmacy, but I'm not  
25 sure what their record retention policy is in



1           accordance with state or administrative practice  
2           laws. So they would be the primary source for you  
3           to request that, sir.

4           Q     You say in your report that: "Pharmacists have  
5           been trained when determining whether to fill a  
6           prescription for a controlled substance to be alert  
7           for suspicious activity surrounding the  
8           prescription. Licensed or registered pharmacists  
9           in every state are required to complete a formal  
10          education program of didactic and practical  
11          experience."

12                     Did that include how to resolve red flags in  
13           controlled substance prescriptions?

14          A     If I could ask you to direct me to the page you're  
15           reading that from, sir, so I can make sure I  
16           understand and am reading it correctly, please.

17          Q     Page 28.

18          A     Thank you. Okay. I'm there, sir.

19                     Could you repeat the question, please?

20          Q     Sure.

21                     You wrote that: "Pharmacists have been  
22           trained when determining whether to fill a  
23           prescription for a controlled substance to be alert  
24           for suspicious activities surrounding the  
25           prescription. Licensed or registered pharmacists

1 in every state are required to complete a formal  
2 education program of didactic and practical  
3 experience."

4 That applies before they receive their  
5 license; is that correct?

6 A Yes, sir.

7 Q And if you and the NABP is doing its job, it  
8 appropriately tests pharmacists on the licensure  
9 examination to make sure that those pharmacists  
10 seeking to become licensed know how to  
11 appropriately resolve red flags for a controlled  
12 substance prescription, correct?

13 MR. ELSNER: Objection.

14 A That's one of the competencies in the overall state  
15 Rx exams, sir, yes.

16 BY MR. GISLESON:

17 Q And that's a serious competency that the NABP wants  
18 to ensure a pharmacist knows how to perform, right?

19 A If I can clarify, it's not NABP because the state  
20 law exam is developed and the content of that exam  
21 is selected by Ohio. It's the Ohio Board of  
22 Pharmacy or that board determination that that's  
23 critical and that the pharmacist should know that.

24 NABP simply facilitates that process by  
25 creating the exam and administering the exam for

1 the state.

2 Q And throughout the time that you were the executive  
3 director for the NABP, you communicated with the  
4 Ohio Board of Pharmacy, correct?

5 A Yes, sir.

6 Q And was it your understanding, based on your  
7 communications with the Ohio Board of Pharmacy,  
8 that the Ohio Board of Pharmacy believed it was  
9 critical that pharmacists know how to perform a  
10 review of a controlled substance prescription?

11 MR. ELSNER: Objection.

12 A Based on my conversations with executive director  
13 Bill Winsley and its investigators, particularly  
14 after the Volkman case, and what they found there  
15 and what they found with the pharmacies and the  
16 prescribers there, I could say yes, that was a  
17 serious concern of Bill Winsley of the Ohio Board  
18 of Pharmacy at the time, sir.

19 BY MR. GISLESON:

20 Q And the Ohio Board of Pharmacy to your knowledge,  
21 therefore, took appropriate steps to make sure that  
22 pharmacists in Ohio were appropriately trained as  
23 part of their licensure in the resolution of red  
24 flags for controlled substances?

25 MR. ELSNER: Objection.

1       A     The Ohio Board of Pharmacy took all the steps they  
2             could to provide that information to pharmacists  
3             and indicate to them that this was a responsibility  
4             they needed to meet. Ohio Board of Pharmacy also  
5             provided some educational programs, PowerPoints,  
6             but the training goes -- is just -- I'm  
7             interpreting training to mean something hands-on  
8             and very different than what the Ohio board is  
9             charged to do, sir.

10       BY MR. GISLESON:

11       Q     Pharmacists create relationships with patients,  
12             true?

13             MR. ELSNER: Objection.

14       A     Yes, sir.

15       BY MR. GISLESON:

16       Q     Do you believe that the pharmacist who worked for  
17             the chain pharmacies in Lake and Trumbull County  
18             sought to create relationships with their patients?

19             MR. ELSNER: Objection.

20       A     I have no idea how to answer that question, sir,  
21             because I'm not familiar with the pharmacists or  
22             the patients.

23       BY MR. GISLESON:

24       Q     In evaluating whether a prescription for a  
25             controlled substance was issued for a legitimate

1 medical purpose, is it appropriate for the  
2 pharmacist to take into consideration whether the  
3 pharmacist has a preexisting relationship with a  
4 patient?

5 MR. ELSNER: Objection.

6 A Yes, sir.

7 BY MR. GISLESON:

8 Q So for example, would you expect, based on your  
9 experience as pharmacist as well as the executive  
10 director of the National Boards of Pharmacies, that  
11 a pharmacist may develop over time an understanding  
12 of the health conditions that led to a particular  
13 patient taking prescription opioid medications?

14 MR. ELSNER: Objection.

15 A Yes, sir.

16 BY MR. GISLESON:

17 Q Did you investigate as part of the work you did in  
18 this case the extent to which any of the chain  
19 pharmacy pharmacists had an existing relationship  
20 for any of the patients for whom you have  
21 identified a flagged prescription?

22 A No, sir.

23 Q Do you have any understanding how many patients  
24 with flagged prescriptions were existing patients  
25 known to the pharmacists?

1       A     No, sir, but that information should have been  
2             documented and included in the patient record. And  
3             I didn't have access to that information, sir.

4       Q     What patient record?

5             MR. ELSNER: Objection.

6       A     The patient profile or documentation, so that no  
7             pharmacist I'm aware of works 24 hours a day, seven  
8             days a week, so if there are other pharmacists in  
9             the pharmacy that didn't have that relationship  
10            with the patient, and didn't know that patient  
11            history, documentation in that patient profile, or  
12            with that prescription, would help that pharmacist  
13            understand and realize those red flags had been  
14            resolved, sir.

15       BY MR. GISLESON:

16       Q     Between 2006 and the present, were pharmacies  
17             required to maintain a patient profile for every  
18             patient that was being served by the pharmacy?

19             MR. ELSNER: Objection.

20       A     The dispensing systems that the states required  
21             required that there be patient records and whether  
22             that was an actual patient profile or some other  
23             documentation, the pharmacies were required to  
24             document that information and maintain that  
25             information.

1 BY MR. GISLESON:

2 Q What was the information in Rite Aid's patient  
3 profile by category?

4 MR. ELSNER: Objection.

5 A I don't know, sir. I didn't have access to that  
6 information.

7 BY MR. GISLESON:

8 Q Did you request access to Rite Aid's patient  
9 profile for the flagged prescriptions from the  
10 plaintiff's lawyers?

11 MR. ELSNER: Objection.

12 A I didn't request the profile. I understand there's  
13 a request that's been made for the patient notes of  
14 the defendants, but I am not sure what the status  
15 of that is.

16 BY MR. GISLESON:

17 Q Did you review the patient profiles for any of the  
18 flagged prescriptions for any of the chain  
19 pharmacies in this case?

20 MR. ELSNER: Objection.

21 A No, sir.

22 BY MR. GISLESON:

23 Q Is it appropriate, in your view, for a pharmacist  
24 to review a patient profile maintained by the  
25 pharmacy in evaluating whether to fill a

1 prescription for opioid medications?

2 A Yes, sir.

3 Q Does a patient profile contain information relating  
4 to a drug utilization review?

5 MR. ELSNER: Objection.

6 A It should, sir. I can't comment as to whether each  
7 patient's profile contains that information, but it  
8 should, sir.

9 BY MR. GISLESON:

10 Q How many of the pharmacists who fill prescriptions  
11 on your flagged prescription list, did you report  
12 to the Ohio Board of Pharmacy for violating their  
13 corresponding responsibility?

14 MR. ELSNER: Objection.

15 A I think if we go back to your earlier questions and  
16 my responses, sir, I did not look at individual  
17 prescriptions, so I did not have access to who the  
18 individual pharmacist or prescribers were in each  
19 of those cases.

20 BY MR. GISLESON:

21 Q So none of the dispensing data you had identified  
22 the pharmacist who filled a prescription?

23 MR. ELSNER: Objection.

24 A Not personally identifiable information, sir.

25 There may have been initials, but the information I



1           looked at did not identify the pharmacist.

2           BY MR. GISLESON:

3           Q     Did you report to anyone with the Ohio Board of  
4                 Pharmacy, that in your view, a large number of  
5                 pharmacists at CVS, Rite Aid, Walgreens, Walmart,  
6                 and Giant Eagle violated their corresponding  
7                 responsibility based on your review of aggregate  
8                 data?

9                 MR. ELSNER:  Objection.

10          A     Knowing the workings of the state boards of  
11                 pharmacy, sir, the answer is no, because I'm not  
12                 sure whether or not the Ohio Board of Pharmacy took  
13                 action against these pharmacists or has them under  
14                 investigation.  And I defer to the Ohio Board of  
15                 Pharmacy.

16                 If I'm presented with information to that  
17                 extent, then it would be my responsibility to  
18                 report those pharmacists and those companies to the  
19                 Ohio Board of Pharmacy.

20          BY MR. GISLESON:

21          Q     The Ohio Board of Pharmacy does inspections of  
22                 pharmacies in Lake and Trumbull County, correct?

23          A     Yes, sir.

24          Q     And they have the ability as part of those  
25                 inspections to look at a pharmacy's dispensing

1 system, correct?

2 MR. ELSNER: Objection.

3 A Yes, sir.

4 BY MR. GISLESON:

5 Q In fact, isn't it true that the Ohio Board of  
6 Pharmacy must approve any dispensing system used by  
7 a pharmacy in Ohio?

8 MR. ELSNER: Objection.

9 A I believe that was a requirement at one time. I'm  
10 not sure if it still is, but yes, sir.

11 BY MR. GISLESON:

12 Q As part of your role as executive director of the  
13 NABP, did the NABP at any time ever instruct the  
14 Ohio Board of Pharmacy or advise the Ohio Board of  
15 Pharmacy that it should review a pharmacy's  
16 dispensing system to determine whether it analyzes  
17 data to identify patterns of diversion?

18 MR. ELSNER: Objection.

19 A We're talking about different systems here, sir.  
20 So if I can clarify, in a pharmacy, there are  
21 numerous systems that the pharmacist has available.  
22 There's a dispensing system that may focus on  
23 processing a prescription and adjudicating the  
24 claim. And then there's a DUR process, patient  
25 profile process, and other patient information.

1 NABP did instruct the Ohio Board of Pharmacy  
2 through the model practice act as to what those  
3 requirements should be in total. And then as we  
4 went through with the prior attorney, what the  
5 automated systems needed to document, but did not  
6 say it had to be specific to dispensing, but it had  
7 to be available, readily available to the  
8 pharmacists to make a determination on each  
9 individual prescription, sir.

10 BY MR. GISLESON:

11 Q Is there an average in the pharmacy industry for  
12 how long a pharmacist should take to fill a  
13 controlled substance prescription?

14 A Not that I'm aware of, sir.

15 Q Is there an average in Ohio for how long it should  
16 take a pharmacist to fill a controlled substance  
17 prescription?

18 MR. ELSNER: Objection.

19 A Not that I'm aware of, sir.

20 BY MR. GISLESON:

21 Q Have you ever analyzed as part of your work in this  
22 case, how long a pharmacist working for one of the  
23 chain pharmacies should take to evaluate a  
24 prescription for a controlled substance to  
25 determine whether it has a legitimate medical

1           purpose?

2           MR. ELSNER: Objection.

3       A     The analysis that I've done is that depending upon  
4           each prescription, that time could vary, just like  
5           other medications, if it's a complicated situation,  
6           it could take longer than less than a situation  
7           that may not be as complicated.

8       BY MR. GISLESON:

9       Q     I understand that you take issue with the chain  
10           pharmacies' policies that they had. Did you do  
11           anything to investigate the knowledge that any of  
12           the pharmacists for the chain pharmacies had that  
13           was independent of any policies or training that  
14           they received from the chain pharmacies?

15           MR. ELSNER: Objection.

16       A     Again, Mr. Gisleson, I'm having a little trouble  
17           understanding the question.

18           Can you rephrase it or help me so I can better  
19           answer it?

20       BY MR. GISLESON:

21       Q     Sure.

22           Did you make any effort to determine what  
23           information or knowledge the pharmacists who worked  
24           for the chain pharmacies in Lake and Trumbull  
25           County had about evaluating controlled substance

1 prescriptions that was separate and apart from any  
2 information they learned from the chain pharmacies?

3 MR. ELSNER: Objection.

4 A No, sir.

5 BY MR. GISLESON:

6 Q Did you review Rite Aid's computer-based training  
7 they provided to pharmacists?

8 A If it was included in the policies and procedures,  
9 then the answer was yes, sir.

10 Q All of it?

11 A Again, I reviewed all the policies and procedures  
12 that were provided to me for Rite Aid.

13 Q Can you identify any pharmacist in either Lake  
14 Trumbull County who filled a prescription for an  
15 opioid medication with actual knowledge that the  
16 prescription lacked a legitimate medical purpose?

17 A I can answer that any pharmacist that filled a  
18 prescription that had an unresolved red flag  
19 knowingly and willfully filled that prescription  
20 and had knowledge that it was not for a legitimate  
21 medical purpose until it was resolved, and that  
22 knowingly and willingly, that has been a guidance  
23 issued by the DEA and it says that ignorance or not  
24 knowing does not negate the fact that the  
25 pharmacist should have known that that was a red

1 flag and should have been resolved.

2 Q And the only basis you have for identifying whether  
3 a pharmacist knowingly and willfully filled a  
4 prescription with an unresolved red flag is that  
5 you have not seen any documentation showing that  
6 the red flag or red flags were resolved; is that  
7 right?

8 A No, sir.

9 MR. ELSNER: Objection.

10 A The other two data points are the significant  
11 number of prescription opioids that were  
12 distributed in Lake and Trumbull County and the  
13 number of opioid and prescription drug overdoses in  
14 those two counties that point to the fact that  
15 there was significant number of prescriptions  
16 written for nonlegitimate purposes.

17 BY MR. GISLESON:

18 Q For the overdoses in Lake and Trumbull County, did  
19 you do any investigation to determine whether the  
20 individuals who overdosed obtained those  
21 prescription medications from one of the chain  
22 pharmacies in this case?

23 A Not specifically, sir.

24 Q Even generally? Do you have any evidence that even  
25 a single person who overdosed in Lake and Trumbull

1 County obtained the prescription opioid medication  
2 from one of the chain pharmacies in this case?

3 MR. ELSNER: Objection.

4 A Not specific to a person, but again, the data  
5 indicate that with that many prescriptions that the  
6 chains were distributing and if the -- in the  
7 chains, the industry numbers say dispensed 70 to  
8 80 percent of all prescriptions, that would  
9 indicate to me that at least one person or more  
10 received a prescription from a chain pharmacy in  
11 those two counties.

12 BY MR. GISLESON:

13 Q So that's an inference that you are drawing,  
14 correct?

15 A It's an inference based on hard data that the  
16 industry is well aware of and has been tested and  
17 analyzed as well.

18 Q Now, you also reference a significant number of  
19 opioid medications that were dispensed in Lake and  
20 Trumbull County. Did you do any investigation as  
21 part of your work in this case what an appropriate  
22 and reasonable quantity of opioid medications was  
23 to be dispensed and consumed in Lake and Trumbull  
24 Counties?

25 MR. ELSNER: Objection.

1       A     Yes. Based upon the quantities of medication that  
2             were identified as excessive, what would be an  
3             appropriate amount of prescriptions in those two  
4             counties would be what the recommended doses would  
5             be for a legitimate medical condition, but I did  
6             not have that information, sir, because I didn't  
7             have documentation to determine how many of those  
8             prescriptions actually the red flags were resolved.

9       BY MR. GISLESON:

10      Q     So you believe that the quantities of medication  
11             for pain that were dispensed were excessive, but  
12             you can't identify what, in your view, is not an  
13             excessive amount, or is an appropriate amount for  
14             Lake and Trumbull County?

15             MR. ELSNER: Objection.

16      A     I could, sir, if I had the data that indicated to  
17             me which one of those prescriptions that were  
18             filled for an excessive amount of prescriptions  
19             were actually legitimate. That would allow me to  
20             calculate what that appropriate amount of opioids  
21             should be for those two counties for legitimate  
22             pain management medications.

23      BY MR. GISLESON:

24      Q     You have not performed that work, correct?

25             MR. ELSNER: Objection.



1       A     The data hasn't been made available to me, so I  
2            have not, sir.

3           BY MR. GISLESON:

4       Q     Does the Ohio Board of Pharmacy to your knowledge  
5            analyze OARRS data to identify prescribers issuing  
6            prescriptions without a legitimate medical purpose?

7           MR. ELSNER:  Objection.

8       A     My understanding of the OARRS data, sir, is that  
9            the Ohio Board of Pharmacy analyzing red flags  
10           associated with prescribers and then sends the  
11           letters to those prescribers when they've  
12           identified problems or other red flags that OARRS  
13           has identified for those prescribers.

14       BY MR. GISLESON:

15       Q     Did the NABP also instruct the Ohio Board of  
16            Pharmacy to send copies of those letters to the  
17            pharmacies who were filling prescriptions for those  
18            prescribers so they know that the Ohio Board of  
19            Pharmacy has a concern about specific opioid  
20            prescribers?

21       A     NABP has no authority or control over the Ohio  
22            Board of Pharmacy and OARRS, so that decision would  
23            have been left to the Ohio board and how they  
24            thought best to manage the registrants and  
25            licensees in Ohio.

1 Q To your knowledge as a former executive director  
2 for NABP, did the Ohio Board of Pharmacy, in fact,  
3 notify any pharmacies in Lake and Trumbull County  
4 of prescribers for whom the board of pharmacy had  
5 concerns?

6 A I'm not aware of that information, sir.

7 Q Did you speak with any doctors in Lake or Trumbull  
8 Counties about prescribing practices in those  
9 counties?

10 A No, sir.

11 Q Did you do any investigation of what the medical  
12 standard of care was in those counties for  
13 prescribing opioid medications?

14 A No, sir, but I don't understand why the standard of  
15 care would be different in Lake and Cook County  
16 than the rest of the country, so I assume it would  
17 be the same standard of care, but I did not do an  
18 analysis of that, sir.

19 Q Are you aware, then, that throughout the country,  
20 including in Ohio, and specifically Lake and  
21 Trumbull County, there was an increase in  
22 prescribing of prescription opioids --

23 MR. ELSNER: Objection.

24 BY MR. GISLESON:

25 Q -- over time?

1 A Yes, sir.

2 Q Is it your view that prescribers exercise their own  
3 professional judgment in deciding whether or not to  
4 prescribe an opioid medication?

5 A It's my understanding, but it's also my  
6 understanding that prescribers engage in diversion  
7 as well.

8 Q Did you report any prescribers in this case to the  
9 Ohio board of medicine?

10 MR. ELSNER: Objection.

11 A Again, sir, I didn't have access to identifiable  
12 information, but if that information becomes  
13 available and it would be my responsibility to  
14 report those practitioners to the medical board.

15 BY MR. GISLESON:

16 Q Did the NABP at any point while you were executive  
17 director ever provide guidance to the Ohio Board of  
18 Pharmacy on when a pharmacy should entirely refuse  
19 to fill a particular prescriber's prescriptions for  
20 opioid medications?

21 A The guidance we talked about earlier with the model  
22 act and the ability of the pharmacist to exercise  
23 their independent judgment. And once that judgment  
24 was made such as not to fill prescriptions, that  
25 there be supporting data to affirm that and data

1           available to the pharmacist to make that decision  
2           the guidance was yes, in that regard.

3           Q     How many prescribers in your view should Rite Aid  
4           have blocked from having their prescriptions filled  
5           at Rite Aid pharmacists in Lake and Trumbull  
6           Counties?

7                     MR. ELSNER:  Objection.

8           A     Every prescriber that Rite Aid identified was  
9           issues prescriptions for nonlegitimate purpose  
10          based upon the data available to the corporation  
11          and the input from the pharmacist, every one of  
12          those prescribers should have been blocked by Rite  
13          Aid.

14          BY MR. GISLESON:

15          Q     And it's your view -- strike that.

16                     Is it your view that once a prescriber in Lake  
17          or Trumbull County issued one opioid medication  
18          prescription without a legitimate medical purpose,  
19          then that means that all of that prescriber's  
20          opioid prescriptions are invalid and illegitimate?

21          A     No, sir.

22          Q     Do you agree that a prescriber can write some  
23          prescriptions without a legitimate medical purpose,  
24          while at the same time writing other prescriptions  
25          that do have a legitimate medical purpose?

1 MR. ELSNER: Objection.

2 A I agree that that could occur, but it doesn't make  
3 any sense to me, sir. So why a physician or  
4 prescriber would want to write prescriptions for a  
5 nonlegitimate purpose jeopardize their license and  
6 jeopardize that patient's life. So yes, it can  
7 happen. But there's no logical speculation as to  
8 why it should happen.

9 BY MR. GISLESON:

10 Q Can you identify any prescriber in Lake or Trumbull  
11 County who intentionally issued opioid  
12 prescriptions knowing that they lacked a legitimate  
13 medical purpose?

14 MR. ELSNER: Objection.

15 A Again, absent the individual data, I cannot do  
16 that, sir.

17 BY MR. GISLESON:

18 Q Did you identify any guidance that the NABP issued  
19 to any state board of pharmacy identifying a  
20 formula or methodology to determine how many red  
21 flag prescriptions will result in diverted opioid  
22 medications?

23 MR. ELSNER: Objection.

24 A The only guidance that we provided, sir, was  
25 information from the DEA that said that the more

1 red flags a prescription has and based upon the  
2 individual red flag, then the potential or  
3 possibility of diversion is related to that and it  
4 could increase exponentially.

5 BY MR. GISLESON:

6 Q Are you aware of any formula or methodology used in  
7 the pharmacy industry or practice that allows a  
8 determination of the number of diverted  
9 prescriptions based on the number red flagged  
10 prescriptions?

11 A Yes, sir.

12 Q What's that?

13 A I can't remember the exact time, but there was an  
14 emergency room physician in Ohio that developed a  
15 program called NARxCHECK. NAPB purchased  
16 NARxCHECK, and what does NARxCHECK does, it looks  
17 at the red flags of a patient and prescriber, such  
18 as how many pharmacies that patient has visited,  
19 how many prescribers the MMEs of controlled  
20 substances, and generates a score for that patient  
21 very similar to what the score would be as a credit  
22 score.

23 And the higher the score, the more potential  
24 for diversion that would occur, and that program is  
25 available to any pharmacy and any pharmacist. And

1           in fact, the defendants -- some of the defendants  
2           in this case actually use NARxCHECK as an algorithm  
3           to help detect red flags and help detect diversion  
4           as well.

5       Q     Any other formulas or methodologies you can  
6           identify?

7       A     Not specifically beyond NARxCHECK, sir.

8       Q     Did you do any investigation, whether pharmacies  
9           who the counties didn't sue, were filling  
10          prescriptions for opioid medications without a  
11          legitimate medical purpose?

12      A     The scope of the lawsuit was outside of my  
13          expertise. I was simply asked to look at  
14          corresponding responsibility red flags. How the  
15          lawyers handled that and proceeded, I had no  
16          information, access, or input into that, sir.

17      Q     Did you have any understanding as to how many  
18          opioid pills pharmacies other than the chain  
19          pharmacies in this case dispensed between 2006 and  
20          2020?

21               MR. ELSNER: Objection.

22      A     In Ohio or nationwide? The answer --

23               BY MR. GISLESON:

24      Q     I'm sorry, Lake and Trumbull Counties.

25               MR. ELSNER: Objection.

1 A No, sir.

2 BY MR. GISLESON:

3 Q Do you know whether any opioid medications were  
4 illegally being sold in Lake and Trumbull Counties?

5 MR. ELSNER: Objection.

6 A My scope was to look at the red flags corresponding  
7 responsibility. I did not look at that factor,  
8 sir.

9 BY MR. GISLESON:

10 Q Now, you say the dispensing data should have been  
11 reviewed by each chain pharmacy to identify  
12 patterns of diversion. Did you identify patterns  
13 of diversion in this case based on your review of  
14 the aggregate dispensing data?

15 MR. ELSNER: Objection.

16 A I identified red flags that indicated the potential  
17 for diversion based on the aggregate data, sir.

18 Q Right. But you reviewed dispensing data. Based on  
19 your review of that dispensing data, did you  
20 identify any patterns of diversion?

21 MR. ELSNER: Objection.

22 A For the sample of dispensing data provided to me by  
23 each of the defendants, yes.

24 BY MR. GISLESON:

25 Q What was the pattern?



1 MR. ELSNER: Objection.

2 A There were different patterns that existed. They  
3 were patients that were receiving duplicative  
4 therapy or combinations. There were patients  
5 receiving the same medications, pattern  
6 prescribing. So in the limited sample, I was able  
7 to identify those red flags and those patterns.

8 BY MR. GISLESON:

9 Q So in your view, once a pharmacy identifies what it  
10 considers to be a pattern of diversion for a  
11 particular patient or a particular prescriber, the  
12 pharmacist then should refuse to fill a  
13 prescription presented by a patient?

14 MR. ELSNER: Objection.

15 A It's my opinion, sir, that once the pharmacist  
16 identifies a red flag and a pattern of red flags,  
17 it's the pharmacist's responsibility to resolve  
18 those red flags. If they cannot resolve those red  
19 flags, and they understand that diversion is  
20 occurring, then until that matter is addressed by  
21 either reporting that prescriber to the medical  
22 board and DEA, or alerting local authorities that  
23 the patient is diverting medications and having  
24 them investigate, then the pharmacist should not  
25 fill prescriptions from that prescriber, nor

1           dispense controlled substances to that patient.

2           BY MR. GISLESON:

3           Q     And exercising a pharmacist's corresponding  
4                 responsibility, is it your view that a pharmacist  
5                 should refuse to fill a prescription solely because  
6                 the pharmacy identified a potential pattern of  
7                 diversion associated with either the patient or the  
8                 prescriber?

9           A     Until the pharmacist has resolved what those issues  
10                were for the red flags and is assured that the  
11                patient is not abusing or diverting those  
12                medications, which then goes outside of the system  
13                and kills people, until that's resolved, the answer  
14                is yes, sir.

15          Q     Okay. So in your view, then, a pharmacist upon  
16                 receiving information from the pharmacy about a  
17                 potential pattern of diversion can include that  
18                 information among the mix of facts and  
19                 circumstances on which the pharmacist relies?

20                MR. ELSNER: Objection.

21          A     Yes, sir.

22           BY MR. GISLESON:

23          Q     And in your view, depending on the pharmacist's  
24                 exercised professional judgment, it still may be  
25                 appropriate to fill that prescription for a

1 particular patient, true?

2 A In some cases, sir.

3 Q Yes?

4 A Yes, in some cases.

5 Q Do you believe that the DEA could identify patterns  
6 of diversion from OARRS data?

7 MR. ELSNER: Objection.

8 A I can't speak for the DEA, but I can tell you that  
9 I've identified patterns of diversion from the  
10 OARRS data and other PDMP programs.

11 BY MR. GISLESON:

12 Q You refer in your report to Rite Aid's 2009  
13 settlement with the DEA. Did you actually read  
14 that DEA settlement agreement?

15 A Again, just so we're on the same page, is there a  
16 specific page in my report? I just want to make  
17 sure I'm understanding you correctly.

18 Q 55 to 56.

19 A Thank you, sir. Are you referring to the bottom of  
20 page 56, stepping into 2009?

21 Q That sounds right.

22 A Yes, sir, I did review that.

23 Q Okay. So that you knew and you know that that  
24 settlement agreement did not involve the State of  
25 Ohio, correct?

1 MR. ELSNER: Objection.

2 A I don't recall, but I would say until I have a  
3 chance to review that, I can't say definitively. I  
4 read it, reviewed it, but I can't recall all the  
5 facts, sir.

6 BY MR. GISLESON:

7 Q Do you know who Janet Hart is?

8 A Yes, I do, sir.

9 Q What role does she have at Rite Aid?

10 MR. ELSNER: Objection.

11 A I know that she's involved in compliance or  
12 operations and that she was one of the witnesses  
13 deposed in this matter.

14 BY MR. GISLESON:

15 Q Was she ever the -- did she ever -- strike that.

16 Did she ever have any -- strike that.

17 Did Janet Hart ever have a role in the  
18 Pennsylvania Board of Pharmacy?

19 A Yes, sir.

20 Q What was her role?

21 A As various times she served as member and at  
22 certain points she was actually president of the  
23 Pennsylvania board.

24 Q Did you ever discuss with her Rite Aid's practices  
25 for dispensing opioid pain medications?

1 A Yes.

2 MR. ELSNER: Objection.

3 BY MR. GISLESON:

4 Q Did you ever tell Janet Hart, whether in writing or  
5 orally in a conversation, that Rite Aid's  
6 pharmacists had to document the resolution of red  
7 flags for controlled substance prescriptions?

8 A As part of a conversation involving Rite Aid's  
9 practices, yes.

10 Q When?

11 A When Rite Aid was instructed by -- or taken to task  
12 by the boards of pharmacy for the red, white, or  
13 15-minute rules that created significant  
14 controversy, and discussions with Janet Hart and  
15 others from Rite Aid, the whole question of how  
16 long it takes to fill a controlled substance, how  
17 the pharmacists were being unduly pressured to  
18 respond to those metrics, and how it was important  
19 that the pharmacist document those situations and  
20 have the time to document it was part of that  
21 discussion, sir.

22 Q Were those discussions in writing in any way?

23 A They were verbal, but I believe if you go back and  
24 check the minutes of the boards that took action  
25 against Rite Aid or raised a complaint, that Janet

1 Hart and others from Rite Aid spoke to that.

2 And I know for a fact that the boards of  
3 pharmacy raised those various issues in those  
4 public discussions and recorded meetings.

5 Q And the issue was the amount of time -- strike  
6 that.

7 The issue was any time guidelines or  
8 requirements for filling a prescription?

9 MR. ELSNER: Objection.

10 A There were several issues, corporate pressure on  
11 pharmacists to fill those prescriptions in an  
12 amount of time, not having enough time to perform  
13 the due diligence, not documenting what was  
14 occurring and pharmacists feeling that because of  
15 that, they were dispensing prescriptions they  
16 shouldn't dispense, but if they didn't dispense  
17 them, that they would be fired by the corporation.

18 BY MR. GISLESON:

19 Q Did you speak with any Rite Aid pharmacists to  
20 express the view that they might be fired if they  
21 didn't dispense a controlled substance?

22 MR. ELSNER: Objection.

23 A Yes, sir.

24 BY MR. GISLESON:

25 Q Do you know the names?

1 A No, sir.

2 Q So you would expect Janet Hart, then, to know what  
3 guidance the NABP was providing to state boards of  
4 pharmacy concerning whether it was necessary to  
5 document the resolution of red flags?

6 A I would expect that Janet Hart, because she's a  
7 very knowledgeable person, would know in general  
8 what NABP's recommendations were. But she would be  
9 looking at Pennsylvania and incorporating NABP, but  
10 I would not expect her to have the same knowledge  
11 that I do or somebody that was a staff person or  
12 member of the board of directors of NABP to have,  
13 sir.

14 Q Did you at any point tell the Pennsylvania Board of  
15 Pharmacy that Janet Hart should not be on the board  
16 of pharmacy or its president?

17 A NABP would never do that, sir, and I would never do  
18 that personally, so the answer is no.

19 Q Do you believe that Janet Hart gave any  
20 instructions to Rite Aid pharmacists to fill  
21 prescriptions for opioid pain medications even if  
22 they lacked a legitimate medical purpose?

23 MR. ELSNER: Objection.

24 A I would have no way to answer that question, sir.  
25 I don't know what Janet Hart said to pharmacists

1           and Rite Aid, or what she would be instructed to  
2           say to pharmacists in her role.

3           BY MR. GISLESON:

4           Q     Was there anyone else at Rite Aid with whom you had  
5                 a discussion whether Rite Aid pharmacists had to  
6                 document resolution of red flags?

7           A     Former employee of Rite Aid, Michael Podgurski.

8           Q     What position did he have?

9           A     I believe he was at one time, Janet Hart's boss.

10          Q     What was that discussion?

11          A     Same discussion as with Janet Hart.

12          Q     Anything different or in addition?

13          A     I think there was pretty extensive discussion and  
14                 pretty significant.

15          Q     When did that discussion secure?

16          A     Again, right after Rite Aid was taken to task by  
17                 the state boards of pharmacy for its imposition of  
18                 metrics to fill prescriptions in a certain amount  
19                 of time, sir.

20          Q     Did you do any analysis of Rite Aid's staffing at  
21                 its pharmacies in Lake or Trumbull Counties?

22          A     No, sir.

23          Q     Did you do an analysis of staffing at any other  
24                 chain pharmacy in Lake or Trumbull County to  
25                 determine whether that staffing was adequate?



1 A No, sir.

2 Q Did you do any analysis for any chain pharmacy in  
3 this case to determine whether any time limits or  
4 time guarantees relating to filling opioid  
5 prescription medications interfered with their  
6 exercise of corresponding responsibility?

7 A I'm sorry. Did you say other pharmacies outside of  
8 Rite Aid?

9 Q Any pharmacies. Any of the chain pharmacies in  
10 this case. Did you do any analysis to determine  
11 whether any time limits or time guarantees relating  
12 to filling opioid medications interfered with their  
13 exercise of corresponding responsibility?

14 A The analysis was information that NABP and I  
15 received firsthand from pharmacists in those  
16 chains, information from the American Pharmacists  
17 Association, which is included in my report, and  
18 then the resolution passed by the members of NABP  
19 that asked NABP to look at the situation because of  
20 reports state boards of pharmacy were hearing that  
21 those metrics were interfering with the  
22 pharmacists' ability to conduct their due  
23 diligence.

24 Q Can you identify any prescription listed among your  
25 flagged prescriptions for which a pharmacist failed

1 to clear a red flag because that pharmacist was  
2 under time pressure?

3 MR. ELSNER: Objection.

4 A I can't identify individual prescriptions but,  
5 again, my report talks about the impact that had  
6 based on the aggregate data.

7 BY MR. GISLESON:

8 Q Is it true that when the Ohio Board of Pharmacy  
9 does an inspection of a pharmacy in Lake or  
10 Trumbull County, that one of the issues that's  
11 evaluated is staffing levels?

12 A I don't know if that's restricted to just Lake and  
13 Trumbull County, sir. I think it's a metric that  
14 they look at all pharmacies.

15 Q All pharmacies throughout Ohio?

16 A I believe so, sir.

17 Q Do you also understand that the Ohio Board of  
18 Pharmacy, when doing an inspection, also evaluates  
19 whether improper dispensing occurred?

20 A I'm not specifically aware, but believe that would  
21 be one of the tenets, again, that the board of  
22 pharmacy would look at.

23 Q Does the board of pharmacy also look at whether  
24 pharmacists for a particular pharmacy have access  
25 to OARRS to request reports when needed?

1       A       I believe in 2011 and then in 2015, when OARRS  
2               became mandatory first for certain drugs, and then  
3               for certain drugs with red flags, and then for  
4               certain drugs identified by the board of pharmacy,  
5               since that was a mandate and a requirement that the  
6               Ohio Board of Pharmacy would have looked for that,  
7               sir.

8       Q       When was the first time that NABP advised the Ohio  
9               Board of Pharmacy that it should be mandatory for  
10              pharmacists in Ohio to check OARRS with respect to  
11              every single prescription for opioid medications  
12              that are presented to the pharmacist?

13             MR. ELSNER:  Objection.

14      A       NABP made that recommendation to all states beyond  
15               Ohio that the PDMP should be utilized for all  
16               controlled substances prior to dispensing, and that  
17               prescribers should also be mandated to check the  
18               PDMP.  And that might have been right at the  
19               beginning of PDMP's -- when they were first  
20               initiated, but I can't recall the specific dates,  
21               sir.

22             BY MR. GISLESON:

23      Q       So was that sometime around 2011?

24      A       Again, it was early on in the PDMPs.  I'm not sure  
25               if it was 2010, 2011 or so.

1 Q Did Ohio follow the recommendation that the NABP  
2 made?

3 A I believe in 2011 they mandated it for  
4 prescriptions with red flags, and then I believe in  
5 2015 they mandated it for all drugs designated by  
6 Ohio.

7 Q Were the pharmacies in Lake and Trumbull County and  
8 the rest of Ohio required to comply with the  
9 requirements of the Ohio Board of Pharmacy and Ohio  
10 law or with NABP's views as to how things should  
11 be?

12 MR. ELSNER: Objection.

13 A Of course, only Ohio law. NABP is not a government  
14 agency and has no authority over pharmacists,  
15 pharmacies, or state boards of pharmacy.

16 MR. GISLESON: Those are the questions I have.  
17 Thank you, Mr. Catizone. Josh?

18 THE WITNESS: Thank you, sir.

19 MR. KOBRIN: Let's go off the record real  
20 quick.

21 THE VIDEOGRAPHER: We are off the record at  
22 10:32 a.m.

23 (A recess was taken.)

24 THE VIDEOGRAPHER: This is Media Number 3 in  
25 the deposition of Carmen Catizone. Today is

1           June 16th, 2021. We're going back on the record at  
2           10:48 a.m.

3           CROSS-EXAMINATION

4           QUESTIONS BY JOSHUA KOBRIN:

5           Q     Hi, Mr. Catizone. My name is Josh Kobrin, I  
6                 represent Giant Eagle. We're going to primarily be  
7                 looking at your May 19, 2021, supplemental report.  
8                 I'll probably refer to that as just the report.  
9                 Does that sound all right to you?

10          A     Yes, sir.

11          Q     Yesterday during your deposition with Mr. Bush, he  
12                 asked you some questions about doctor shopping.

13                 Do you remember that?

14          A     Yes, sir.

15          Q     And you talked about why you chose two or more  
16                 prescribers as your metric for doctor shopping.

17                 Do you remember that?

18          A     Yes, sir.

19          Q     And you said that was your decision to measure  
20                 doctor shopping as overlapping days of supply  
21                 written by two or more prescribers, correct?

22          A     Yes, sir.

23          Q     And I believe part of the reason for that decision  
24                 was as you stated, quote/unquote, because patients  
25                 generally use one physician; is that correct?

1 A The data indicated that, sir.

2 Q Did the data -- your reason for selecting that  
3 metric was the data indicated that patients  
4 generally use one physician?

5 MR. ELSNER: Objection.

6 A Yes.

7 BY MR. KOBRIN:

8 Q And your concern here, and this is kind of also  
9 from your report, as you explained in your report,  
10 is that: "A patient presenting a prescription for  
11 a controlled substance" -- and I'm reading from  
12 your report now on page 35 -- "may be obtaining the  
13 same or similar controlled substance from a  
14 different prescriber/prescribers, and the patient  
15 does not make the prescriber aware of the other  
16 prescriber."

17 Did I read that correctly?

18 A Yes, sir.

19 Q So given this concern, does the doctor shopping  
20 metric that you created for your report here, does  
21 it include -- or does it, rather, does it flag  
22 prescribers who work together in the same medical  
23 practice?

24 MR. ELSNER: Objection.

25 A If there's continuity of care and that is

1           documented as the red flag that that physician is  
2           covering for the other prescriber, then it would  
3           not be a red flag, but the documentation would  
4           verify that, sir.

5           BY MR. KOBRIN:

6           Q     Yeah. I'm just wondering, your red flags here, the  
7           number of red flags here on page 35, does that  
8           include doctors who are working together in the  
9           same medical practice?

10           MR. ELSNER: Objection.

11           A     That was the analysis done by Mr. McCann. I can't  
12           answer that, sir.

13           BY MR. KOBRIN:

14           Q     Was that intended to include doctors who were  
15           working together in the same medical practice?

16           MR. ELSNER: Objection.

17           A     Again, I did not run the numbers or the  
18           prescriptions, so I can't answer that, sir.

19           BY MR. KOBRIN:

20           Q     You instructed Mr. McCann on how to identify these  
21           prescriptions, didn't you?

22           A     I identified the red flags, sir, and asked him to  
23           run the numbers based upon the red flags.

24           Q     And you wrote this, right? "The data reveals as  
25           follows regarding patient was dispensed opioid

1 prescriptions in overlapping days prescribed and  
2 were written by two or more prescribers."

3 A Yes, sir.

4 Q You wrote that, right?

5 A Yes, sir.

6 Q Is that intended to capture doctors who are working  
7 together in the same medical practice?

8 MR. ELSNER: Objection.

9 A It was intended to identify whether or not there  
10 were two different prescribers writing for that  
11 that would create duplicative therapy or therapy  
12 that was unknown to the other prescriber.

13 So if the best way to analyze the data was  
14 simply to include that, I don't know. That  
15 decision was Mr. McCann's decision.

16 BY MR. KOBRIN:

17 Q So you don't know one way or the other whether that  
18 includes doctors who where partnered in a medical  
19 practice together?

20 A Correct.

21 Q You don't know one way or the other whether that  
22 includes a physician prescribing for one patient  
23 and a physician's assistant also prescribing for  
24 the same patient in collaboration with the  
25 physician?



1       A       I don't know that, but the way the red flag was set  
2               up, there would be no reason for those two to  
3               prescribe duplicative therapy that this would  
4               identify as well.

5       Q       I think you talked about yesterday that there are  
6               situations in which a doctor or practice might  
7               change a therapy, you might have a therapy that's  
8               overlapping because, one is short-acting and one is  
9               long-acting but there are different situations  
10              where there might be, correct, duplicative  
11              therapies?

12      A       Not so much duplicative, but change in therapy, and  
13               that change would be documented in the pharmacists  
14               notes and patient record.

15      Q       Would those be flagged in this flag Number 2,  
16               doctor shopping in your report?

17              MR. ELSNER:  Objection.

18      A       Again, I can't answer that.  I did not analyze the  
19               data, sir.

20              BY MR. KOBRIN:

21      Q       So you just -- what did you tell Mr. McCann to do  
22               for this?

23              MR. ELSNER:  Objection.

24      A       I identified the red flags based upon my pharmacy  
25               knowledge and experience and asked Mr. McCann to

1 identify the prescriptions and total those  
2 prescriptions based upon the description I gave of  
3 those red flags.

4 BY MR. KOBRIN:

5 Q And for this red flag metric you just said, any two  
6 prescribers?

7 A It was the information --

8 MR. ELSNER: Objection.

9 A -- that's presented there in the report, sir, about  
10 different prescribers.

11 BY MR. KOBRIN:

12 Q That's what you gave him?

13 A Yes.

14 Q That one sentence, the data reveals as follows?

15 A Yes, sir.

16 Q Did you give him that in a written form?

17 MR. ELSNER: Objection.

18 A It was part of my draft report.

19 BY MR. KOBRIN:

20 Q So you gave him a draft report and then he gave you  
21 the numbers to fill in in the chart here?

22 MR. ELSNER: Objection.

23 A That was the first report.

24 BY MR. KOBRIN:

25 Q Is that correct?

1       A       That was the first report, for that first report,  
2               that was one of the exhibits.

3       Q       The document that you gave to Mr. McCann was one of  
4               the exhibits to the first report?

5       A       No, no.

6               MR. ELSNER:  Objection.

7       A       The first report.

8       BY MR. KOBRIN:

9       Q       Right.  So before he gave you the numbers is what  
10              I'm talking about.  Before you came out and you had  
11              served any report, what did you give to Mr. McCann?

12             MR. ELSNER:  Objection.

13      A       Mr. McCann received the draft report of what my red  
14              flags were and how I described those red flags,  
15              sir.

16      BY MR. KOBRIN:

17      Q       Have you produced that draft report that you gave  
18              to Mr. McCann, Dr. McCann?

19             MR. ELSNER:  Objection.

20             MR. KOBRIN:  Have you produced that, Mike?

21             MR. ELSNER:  That's actually not correct.  He  
22              wasn't given a draft report.  He was given the  
23              clauses --

24             MR. KOBRIN:  I don't want you testifying right  
25              now.  We don't have time for that right now.  You

1           can clarify that later.

2           BY MR. KOBRIN:

3           Q     The testimony is that he was going to draft a  
4                 report. Is that correct, Mr. Catizone?

5           A     No, I don't recall --

6           Q     What did you give Dr. McCann?

7           A     I don't recall, sir.

8                     MR. ELSNER: Objection.

9           BY MR. KOBRIN:

10          Q     You don't recall.

11                 Did you give him anything in writing to  
12                 explain your flags?

13                     MR. ELSNER: Objection.

14          A     I don't recall.

15          BY MR. KOBRIN:

16          Q     You don't recall.

17                 How did he know what to do to run these  
18                 algorithms to flag the proper prescriptions that  
19                 you aimed to identify?

20                     MR. ELSNER: Objection.

21          A     I don't recall, sir.

22          BY MR. KOBRIN:

23          Q     You don't recall what you gave him, how you  
24                 instructed him?

25          A     No, sir.

1 MR. ELSNER: Objection.

2 BY MR. KOBRIN:

3 Q Okay. Did you do any research on how researchers  
4 or academics who study pharmacy science and health  
5 administration have defined doctor shopping?

6 MR. ELSNER: Objection.

7 A My research would be the references included in the  
8 report and then my involvement in cases and work  
9 with the DEA, sir.

10 BY MR. KOBRIN:

11 Q I think you already testified that you didn't do  
12 any research on how boards of pharmacy measure  
13 doctor shopping, correct?

14 MR. ELSNER: Objection.

15 A No, sir. I didn't. I didn't testify --

16 BY MR. KOBRIN:

17 Q Yesterday when -- yesterday when Mr. Bush was  
18 asking you questions, I believe you said you were  
19 unaware of the Ohio board of pharmacies doctor  
20 shopping metric; is that correct?

21 A That specific metric, sir, yes.

22 Q In writing this report, then, did you review any  
23 documents that defined doctor shopping?

24 A Yes, sir.

25 Q And how did they define doctor shopping?

1       A     Those documents are included in my references and  
2             they defined them as I've indicated my opinion,  
3             that's my interpretation and analysis of what  
4             doctor shopping is, sir.

5       Q     So you stand by the -- strike that.

6             You rely on the documents stated in your  
7             report for their definition of doctor shopping  
8             rather than the Ohio Board of Pharmacy's definition  
9             of doctor shopping that you were shown yesterday,  
10            correct?

11       A     I relied on that information and my experience and  
12             the fact that the actual definition of doctor  
13             shopping by the Ohio Board of Pharmacy is more than  
14             one practitioner, so the Ohio Board of Pharmacy's  
15             definition is more stringent than my definition,  
16             sir.

17       Q     I'm not sure where that's coming from but we can  
18             talk about that later if there's time. I'm  
19             interested as to where you found that.

20             MR. ELSNER: Objection.

21       BY MR. KOBRIN:

22       Q     So you said you did review some documents that  
23             defined doctor shopping. Let's flip to page 20 of  
24             your report real quick. Section B of your  
25             "Controlled Substances," sorry, just before

1           Section 3, the paragraph just above it, the end of  
2           that paragraph. Do you see where it says -- I'm  
3           going to read from your report: "As rates of PDMP  
4           participation increased, measures of doctor  
5           shopping and prescribing of certain controlled  
6           substances declined. The data suggests that PDMP  
7           utilization helps to promote medically warranted  
8           prescribing and dispensing and assists in detecting  
9           possible controlled substance misuse and  
10          diversion."

11                 Did I read that right?

12       A     Yes, sir.

13       Q     And that's what you wrote in your report, correct?

14       A     Yes, sir.

15       Q     When you say, quote/unquote, measures of doctor  
16           shopping, what measures of doctor shopping are you  
17           referencing?

18       A     The actual incidence of doctor shopping that would  
19           be recorded in the PDMP, sir.

20       Q     Well, what's the metric for doctor shopping in the  
21           PDMP?

22                 MR. ELSNER: Objection.

23                 BY MR. KOBRIN:

24       Q     What's the measure?

25       A     Sure.

1           In the 30-some cases that I've reviewed or  
2           served as an expert witness, in all those cases  
3           I've accessed the PDMP data. And when you analyze  
4           the PDMP data, you look at the number of  
5           prescribers and you look at where those prescribers  
6           are based, whether they're in the same practice or  
7           not, whether or not the patient is going to  
8           different practitioners, and so you formulate a  
9           metric based upon the PDMP data of how many  
10          prescribers that patient is seeing for those  
11          medications. That's the metrics in the analysis,  
12          sir.

13       Q     What is doctor shopping based on that analysis?

14       A     Based upon the Ohio Practice Act Rules, it's more  
15          than one prescriber prescribing the same controlled  
16          substances or controlled substances, and my  
17          interpretation that was just written in the report  
18          is what I view as the red flags.

19       Q     Okay. So when you run the report, you didn't  
20          actually cite anything -- you didn't actually cite  
21          anything in the Ohio practice rules. You cited an  
22          article by the PDMP Center for Excellence article,  
23          mandating PDMP participation by medical providers.  
24          Do you see that in Footnote 18?

25       A     What page, sir?



1 Q It's the footnote that follows right after the  
2 sentence I just read, footnote 18 at the bottom of  
3 page 20.

4 A Oh, okay, yes, sir.

5 Q You didn't say cite any Ohio practice rules that  
6 you allege right now, that you relied upon. You  
7 actually cite this from the article. Do you know  
8 what that article is?

9 MR. ELSNER: Objection.

10 A The article that's cited, sir?

11 BY MR. KOBRIN:

12 Q Yes.

13 A Yes, I do.

14 Q Is that one of the articles you relied on to  
15 understand how practitioners and others within the  
16 industry measure doctor shopping?

17 A The article didn't -- the article just spoke about  
18 doctor shopping and the information contained in my  
19 report. The information from the Ohio medical  
20 board came, because yesterday, Mr. Bush represented  
21 that the standard in Ohio was five or more based on  
22 OARRS reports. And yesterday evening, I actually  
23 reviewed the Ohio practice act and regulations and  
24 found out that that was not the case. That the  
25 Ohio board, so therefore, would not have been a

1 reference in my report because that information  
2 was --

3 (Simultaneous conversation.)

4 A -- yesterday.

5 MR. KOBRIN: Move to strike.

6 BY MR. KOBRIN:

7 Q Is this article what you're relying on for your  
8 statement that: "As rates of PDMP participation  
9 increased, measures of doctor shopping and  
10 controlled substances declined"?

11 MR. ELSNER: Objection.

12 BY MR. KOBRIN:

13 Q What did you rely on to know that fact?

14 A Sure.

15 That was one of the sources. The other  
16 sources was information from the PDMP programs.  
17 NABP operates a steering committee for all of the  
18 PDMP programs. And that steering committee meets  
19 with the administrators of all the PDMP programs  
20 and all the states once a year. And at that  
21 meeting, that discussion occurred.

22 And people reported that when they utilized  
23 PDMP, and provided information on doctor shopping  
24 to pharmacists and prescribers, or pharmacists and  
25 prescribers accessed, and saw doctor shopping, that

1           helped decrease the incidence of that.

2           Q     But you don't know how those people were measuring  
3                 doctor shopping or the incidence of doctor  
4                 shopping, do you?

5           A     They were using similar standards, looking at the  
6                 number of prescribers that I did in my analysis of  
7                 this situation.

8           Q     Did that article, Footnote 18, use a similar  
9                 standard as you did in your analysis of this  
10                situation?

11          A     Again, it was one of the resources that I utilized  
12                 and provided more background information. But my  
13                 actual analysis came based upon actual PDMP reports  
14                 that I reviewed and interactions with the PDMP  
15                 administrators across the country.

16          Q     I'm asking you if the article you cited in support  
17                 of the statement I read used similar standards as  
18                 you in measuring doctor shopping.

19          A     I don't recall the specifics of the article. It  
20                 was one of the sources I used, sir.

21          Q     All right. And that's the only article that you  
22                 cite for that statement, correct?

23                     MR. ELSNER: Objection.

24          A     It's for that statement, but there are other  
25                 articles cited in the document that reference how

1           valuable PDMP is and how they have an impact on the  
2           red flags.

3           BY MR. KOBRIN:

4           Q     Did you cite any other articles in your report that  
5           measured doctor shopping --

6                     MR. ELSNER:  Objection.

7           BY MR. KOBRIN:

8           Q     -- or that you relied on for their measure of  
9           doctor shopping?

10                    MR. ELSNER:  Same objection.

11          A     I would have to go through the report and check to  
12          make sure.  At this point, I can't say  
13          definitively, but I'm sure that there were probably  
14          other references that I used besides my experience,  
15          sir.

16          BY MR. KOBRIN:

17          Q     Right now that's the only one that you cited that  
18          we've found, correct?

19                    MR. ELSNER:  Objection.

20          A     That's the only one on that page.  I said there are  
21          probably others in the report, sir.

22          BY MR. KOBRIN:

23          Q     Okay.  That's the only one that you cite here,  
24          correct?

25                    MR. ELSNER:  Objection.

1       A     Yes, sir. Again, for the -- that's the only one on  
2             this page, but there are probably other sources of  
3             references throughout the document.

4       BY MR. KOBRIN:

5       Q     Do you remember yesterday, Mr. Bush also asked you  
6             several questions about drug cocktails?

7       A     I remember some of the discussions, sir, yes.

8       Q     The measure you applied for the opioid and  
9             benzodiazepine drug cocktail in Number 5, this is  
10            on page 39 of your report, that flagged  
11            prescriptions if they were dispensed within 30 days  
12            of one another, correct?

13      A     Sorry, what page was that, sir?

14      Q     39.

15      A     Okay. And what section?

16             MR. ELSNER: Objection.

17      BY MR. KOBRIN:

18      Q     "Section 5, Drug Cocktail, an opioid and  
19             benzodiazepine."

20             I'll just repeat my question for clarity.

21             The measure you applied for the opioid and  
22             benzodiazepine drug cocktail at Number 5, that  
23             measure flagged prescriptions if they were  
24             dispensed within 30 days of one another, correct?

25      A     Is that reference to page 40?

1 Q I'm on page 39. Are you in your supplemental  
2 report?

3 A Yes.

4 Q May of 2021?

5 A But the actual data and table for that appears on  
6 page 40. It says: "An opioid and a benzodiazepine  
7 were dispensed to a patient within 30 days of one  
8 another."

9 Is that the reference.

10 Q Right. I'm referring to that section, which starts  
11 on page 39, but we can look at page 40 if you want.

12 A I was just trying to find out where you were, sir.

13 Q That's fair.

14 So that flagged prescriptions if they were  
15 dispensed within 30 days of one another, correct?

16 A Yes, sir.

17 Q On what basis did you pick 30 days?

18 A Based upon, again, my review of prior prescription  
19 programs, profiles, PDMPs within that time period.  
20 It would create that problem noted on page 39, that  
21 the combination of an opioid and a benzodiazepine  
22 would create an increased risk of respiratory  
23 depression because those two drugs would still have  
24 the potential to interact during that time frame,  
25 sir.

1 Q Did you use 30 days for all the defendants?

2 A Yes, sir.

3 Q Is that because you wanted to measure dispensing  
4 consistently across all the defendants?

5 A Yes, sir.

6 Q Consistency is important, especially when you are  
7 comparing red flags in a chart like you do on  
8 page 40, correct?

9 MR. ELSNER: Objection.

10 A Yes, sir.

11 BY MR. KOBRIN:

12 Q You don't want to measure dispensing within 20 days  
13 for one defendant, 30 days for another, do you?

14 MR. ELSNER: Objection.

15 A No, sir.

16 BY MR. KOBRIN:

17 Q You wouldn't want to do that.

18 So is it your opinion that your metric applied  
19 consistently across the data sets provided by all  
20 the defendants?

21 A It would be my testimony that Mr. McCann applied  
22 that across all the data sets consistently, yes,  
23 sir.

24 Q And that's your opinion, right, that this metric is  
25 being applied consistently across CVS, Walgreens,

1 Walmart, Giant Eagle, HPC, and Rite Aid, correct?

2 MR. ELSNER: Objection.

3 A Yes, sir.

4 BY MR. KOBRIN:

5 Q And it's your opinion that if we picked a month  
6 during the discovery period, January of 2008, the  
7 metric that's being used in this test, this drug  
8 cocktail test, that would apply consistently to all  
9 defendants in that month, correct?

10 MR. ELSNER: Objection.

11 A I can respond again to the prior question. It  
12 would be my expectation and my instruction that it  
13 should be applied consistently, whether it's one  
14 month or whether it's the total data set, sir.

15 BY MR. KOBRIN:

16 Q Same for the holy trinity red flag at Number 4 on  
17 page 37. That would also apply consistently across  
18 all defendants?

19 MR. ELSNER: Objection.

20 A All of the data in the report should be applied  
21 consistently, sir.

22 BY MR. KOBRIN:

23 Q It's an apples-to-apples comparison between one  
24 defendant pharmacy and another defendant pharmacy,  
25 correct?



1 MR. ELSNER: Objection.

2 A Yes, sir.

3 BY MR. KOBRIN:

4 Q All right. Near the top of page 47 of your report,  
5 you describe the way you measured same hour  
6 prescribing.

7 Do you see that?

8 A Yes, sir.

9 Q According to your report you wanted this to flag a  
10 prescription when: "An opioid was dispensed to at  
11 least three different patients within an hour, and  
12 the opioid prescriptions were for the same base  
13 drug, strength, and dosage form, and were written  
14 by the same prescriber."

15 Did I read that correctly?

16 A Yes, sir.

17 Q So the reason you named this flag same hour  
18 prescribing, is just that its defining feature,  
19 right? These scripts had to be dispensed to these  
20 three patients within an hour of each other, right?

21 A That was one of the defining factors, sir. The  
22 other was the fact that they would be the same  
23 medications, dosages, strengths, and quantities.

24 Q Did you name this or is that Dr. McCann? Did you  
25 name it "same hour prescribing"?

1 MR. ELSNER: Objection.

2 A I'm sorry. I didn't understand the question. I  
3 apologize.

4 BY MR. KOBRIN:

5 Q Did you name this, this metric, same hour  
6 prescribing there, did you name it that?

7 MR. ELSNER: Objection.

8 BY MR. KOBRIN:

9 Q The other one is same day prescribing and this one,  
10 same hour prescribing. Did you name it same hour  
11 prescribing?

12 A When the data came back in the data run, yes, I did  
13 name it that within -- because that's what the data  
14 set showed when they ran the data, so I entitled  
15 that as well.

16 Q Did you instruct Dr. McCann on this data run or did  
17 he do this and give you the data and tell you what  
18 he found?

19 MR. ELSNER: Objection.

20 A Mr. McCann ran the data.

21 BY MR. KOBRIN:

22 Q You didn't give him any instruction on this one?

23 A I think --

24 MR. ELSNER: Objection.

25 A I'm sorry.

1 BY MR. KOBRIN:

2 Q Your answer?

3 A I said, no, sir.

4 Q What expertise does Dr. McCann have to decide that  
5 any dispensing within an hour is relevant at all to  
6 this case?

7 MR. ELSNER: Objection.

8 A I think Mr. McCann's expertise is in analysis. And  
9 performing that analysis if other numbers looked  
10 interesting or significant to what the original  
11 question was, Dr. McCann would present those to me.  
12 And I would make a determination of whether or not  
13 that information was useful or not, sir.

14 BY MR. KOBRIN:

15 Q So Dr. McCann formulated this red flag, correct?

16 MR. ELSNER: Objection.

17 A No. He just simply used the red flag that I gave  
18 him and did additional analysis to see if there was  
19 other data points or data information that would be  
20 useful to me.

21 BY MR. KOBRIN:

22 Q What red flag did you give him that led him to do  
23 this analysis?

24 A The red flag was the pattern prescribing that  
25 appears on page 46 that said, look for patients

1           that receive the same medications from the same  
2           prescribers in the same quantity strengths and  
3           such. That was the instruction given to him.

4       Q     And he added this one-hour element; is that  
5           correct?

6           MR. ELSNER: Objection.

7       A     In analyzing the data, this information came up,  
8           that he asked to me whether it was significant or  
9           not, and it helped to clarify or it helped to  
10          further explain how prevalent and how significant  
11          this red flag was.

12          So I said, "Yes, that would be interesting  
13          data.

14       BY MR. KOBRIN:

15       Q     How did he ask you? Is this a phone conversation,  
16           an email, a document he sent you?

17           MR. ELSNER: Objection.

18       A     The information came to me provided through  
19           counsel, so I don't know how that information was  
20          provided.

21       BY MR. KOBRIN:

22       Q     But you knew that information was from Dr. McCann?

23       A     Yes.

24       Q     And was that in written form?

25       A     Again, the information was provided to me by

1 counsel, so I don't know how it --

2 Q In written form? It was provided to you in written  
3 form?

4 MR. ELSNER: Objection. Do not discuss how --

5 MR. KOBRIN: If he's relying on this, I think  
6 we're going to need to go off the record because  
7 we're running out of time and I would like Special  
8 Master Cohen to make a judgment on this.

9 Could we go off the record?

10 MS. FUMERTON: I agree with that.

11 MR. KOBRIN: We can go off the record.

12 THE VIDEOGRAPHER: Off the record at  
13 11:12 a.m.

14 (A recess was taken.)

15 THE VIDEOGRAPHER: We're going back on the  
16 record at 11:58 a.m.

17 BY MR. KOBRIN:

18 Q Mr. Catizone, good to see you again. I just want  
19 to clarify the record from where we left off  
20 before, if that's okay?

21 A Yes, sir.

22 Q Could you -- thank you. Now I can see you.

23 Just to clarify, your testimony earlier  
24 reflected you had some communication with  
25 Dr. McCann, through attorneys or otherwise, through

1           which you communicated a description of the red  
2           flag you wanted him to run on the data, correct?

3       A     Yes, that was a verbal conversation, sir, yes.

4       Q     And Dr. McCann or his staff, through attorneys or  
5           otherwise, then provided you with information and  
6           data and asked you if it was significant or not,  
7           and whether it helped clarify or further explain a  
8           red flag, correct?

9           MR. ELSNER:  Objection.

10      A     No, sir, that's where I made a mistake.  If I can  
11           explain?

12      BY MR. KOBRIN:

13      Q     Please.

14      A     So in working with legal counsel, I began drafting  
15           a report which I referred to as a draft report,  
16           that's noted in the invoices that we discussed  
17           yesterday.  Whatever conversations, whatever data  
18           analysis was conveyed to Mr. McCann was through  
19           legal counsel.  I never spoke or interacted with  
20           him directly beyond that first phone call.

21           Information then from Mr. McCann was inserted  
22           into my draft report by counsel and I reviewed that  
23           information through my draft reports, sir.

24      Q     So your understanding was that information was  
25           inserted from Dr. McCann into your draft report,

1           which you then edited and integrated into your  
2           draft report?

3           A     Yes, sir.

4           Q     And that information, as you previously testified,  
5                 you understood to be coming directly from  
6                 Mr. McCann through counsel to you?

7           A     I didn't know where that came from. I worked  
8                 directly with counsel. Whatever conversations  
9                 occurred or where it came from, I don't know,  
10                except I asked for the analysis of my red flags and  
11                that was provided to me back by counsel.

12          Q     You previously testified that that information came  
13                 from Dr. McCann. Did you have conversations with  
14                 Dr. McCann about that information?

15          A     No, sir. And in answering your question, I erred  
16                 by focusing on the substance in trying to answer  
17                 the question you were asking. And I didn't realize  
18                 that the process was that important to these  
19                 proceedings. And so, I misspoke or left out the  
20                 detail that all of my connections, all of my  
21                 conversations were directly with legal counsel, and  
22                 what happened on the other side of that, I have no  
23                 idea.

24          Q     Mr. McCann was never on those calls with you and  
25                 legal counsel?

1       A     Just the two calls that I referenced yesterday.  
2             The first call where I verbally explained what my  
3             red flags were, and then a second call after the  
4             supplemental data was analyzed.

5             Beyond that, I had no direct contact with  
6             Dr. McCann at all, sir.

7       Q     Was one of the things that was inserted into your  
8             report, these boxes, where it says "Defendant CVS,  
9             Walgreens, Walmart, HBC, Rite Aid" across the top?

10      A     I'm sorry.

11      Q     Were those inserted into your report?

12      A     What --

13      Q     The boxes that you have under each red flag where  
14             the first row is "Defendant CVS, Walgreens,  
15             Walmart, HBC, Rite Aid," were those boxes inserted  
16             into your report?

17             MR. ELSNER:  Objection.

18      A     The data was inserted there and then I made the  
19             boxes as part of the format, but the data was  
20             provided to me.

21             BY MR. KOBRIN:

22      Q     In what format was the data provided?

23      A     Numbers under the text.

24      Q     So when -- there were just numbers, they weren't in  
25             a box, they weren't in a grid?



1 A No, sir.

2 Q And those numbers you understood were communicated  
3 by Mr. McCann to counsel to you, correct?

4 MR. ELSNER: Objection.

5 A That was a direct conversation with counsel, so...

6 BY MR. KOBRIN:

7 Q Well, you understood that Dr. McCann was doing the  
8 numbers crunching for you, correct?

9 A That was my understanding, sir.

10 Q Counsel wasn't doing the number crunching, correct?

11 A No. I just replied that I understood that it was  
12 Dr. McCann running the numbers, sir.

13 Q So any numbers that were inserted into your draft  
14 reports were from Dr. McCann or his staff, correct?

15 A That would be the assumption, sir.

16 Q Did you ever receive any emails that were forwards  
17 of emails with Dr. McCann and counsel?

18 A No, sir.

19 Q Did you ever see any emails through any means  
20 between Dr. McCann and counsel?

21 A No, sir.

22 Q Did you have any communications on the phone or  
23 otherwise with Dr. McCann's staff?

24 A No, sir, just the two conversations with Dr. McCann  
25 that I've already testified to.

1 Q You never communicated directly or indirectly to  
2 your knowledge with anyone on Dr. McCann's staff?

3 A I have not, sir. I did not, sir.

4 Q All right.

5 MR. KOBRIN: Can we go off the record for a  
6 moment?

7 THE VIDEOGRAPHER: We're going off record at  
8 12:03 p.m.

9 (A recess was taken.)

10 THE VIDEOGRAPHER: We're going back on the  
11 record at 12:10 p.m.

12 BY MR. KOBRIN:

13 Q Mr. Catizone, you worked at a pharmacy, right? I  
14 believe you said you worked at Albertsons in  
15 Chicago; is that correct?

16 A Osco Drug, sir, yes.

17 Q When you worked there, what dispensing software was  
18 the pharmacy using?

19 MR. ELSNER: Objection; asked and answered.

20 A I don't recall, sir.

21 BY MR. KOBRIN:

22 Q PDX?

23 A I don't recall.

24 Q You don't recall?

25 Do you know that not all data regarding hour

1 and minute actions were collected in that system  
2 you used?

3 MR. ELSNER: Objection.

4 A I don't recall the system, so I can't answer the  
5 question, sir.

6 BY MR. KOBRIN:

7 Q Do you know generally that not all hour and minute  
8 actions -- strike that.

9 Do you know generally that not all actions --  
10 strike that.

11 Do you know generally that there's not a  
12 record made of the hour and minute that all actions  
13 are taken in pharmacy dispensing systems?

14 A I know in general that the pharmacy system records  
15 the actual hour and minutes that a prescription is  
16 entered into the system and then also at the point  
17 of sale that the hour and minute that that's  
18 actually transacted is recorded in the system, sir.

19 Q When did the leading pharmacy dispensing systems in  
20 the market begin adding the hour and minute to the  
21 dispensing point of sale transaction?

22 A That's outside of my expertise, sir. I'm sorry, I  
23 don't know.

24 Q Do you know how pharmacy dispensing systems work?

25 A In general, sir, yes.

1 Q You know that at a certain point they did not  
2 capture that hour and minute for the dispense; is  
3 that correct, that that was a recent addition in  
4 the past ten years or so to the pharmacy dispensing  
5 systems?

6 A I do know that the pharmacy dispensing systems have  
7 changed over time and that they went from  
8 typewriters to computer systems. But I'm not sure  
9 when those other changes occurred, sir.

10 Q Do you know whether they collect an hour and data  
11 for the time that the sale is done, where the  
12 actual tech or pharmacists puts pills in a bottle?

13 MR. ELSNER: Objection.

14 BY MR. KOBRIN:

15 Q Do you know that hour and minute when that's  
16 collected?

17 MR. ELSNER: Objection.

18 A Point of sale is when it's actually rang up, rung  
19 up, that is collected. When the technician puts  
20 the medications in the container, that's -- there's  
21 not a time that I'm aware of where that's recorded.

22 BY MR. KOBRIN:

23 Q So there's not a time stamp to show when the fill  
24 is done, pills in bottle?

25 A I think, sir, I'm being confused the sale. When

1 the sale transacts that is recorded, but what the  
2 actual --

3 Q I understand that.

4 I'm talking about the transaction being the  
5 fill, when the pills are actually put into the  
6 bottle. I think you understand, as you've stated,  
7 that that minute and hour, that is not recorded in  
8 the pharmacy dispensing system, correct?

9 A Yes, sir.

10 Q If certain hour and minute data was not collected  
11 for defendants in this case, did you intend for the  
12 same hour prescribing red flag to capture all  
13 prescriptions that were from the prescriber and for  
14 the same drug, but for which there was no available  
15 information about when the opioid was dispensed?

16 MR. ELSNER: Objection.

17 A First, I'm not sure of the question. But what I  
18 expected was data analysis of that particular red  
19 flag. Beyond that, I can't comment, sir.

20 BY MR. KOBRIN:

21 Q Well, did you expect it to pull in all situations  
22 in which there was the same drug and the same  
23 prescriber but there was no time stamp?

24 A What I expected is to have data analysis across all  
25 defendants for that particular red flag.

1 Q I think you earlier said that the same hour issue  
2 was one of the defining factors of the red flag,  
3 correct?

4 A The primary defining factors were the same drug,  
5 same strength, and same dosage. The time that  
6 was -- the time could be another more explicit  
7 determinant of that red flag.

8 Q Well, that's what distinguished it from the same  
9 day prescribing, correct, that and the lower number  
10 of patients, correct?

11 MR. ELSNER: Objection.

12 A Again, I'm sorry, sir. What do you mean by  
13 distinguish --

14 BY MR. KOBRIN:

15 Q Same hour prescribing was one of your flags and  
16 same day of prescribing was one of your flags,  
17 correct?

18 A Yes, sir.

19 MR. ELSNER: Objection.

20 BY MR. KOBRIN:

21 Q And the main difference between same hour  
22 prescribing and same day prescribing is that in  
23 same hour prescribing, it had to be in the same  
24 hour, and it only had to be three patients,  
25 correct?

1 A Correct, sir.

2 Q So you wouldn't have expected that if there were  
3 three patients who had the same base drug,  
4 strength, and dosage, much like the same day  
5 prescribing flag, if you have three patients, same  
6 drug, strength, and dosage, but there was no time  
7 stamp, did you expect that they would get flagged  
8 by the same hour prescribing flag --

9 MR. ELSNER: Objection.

10 BY MR. KOBRIN:

11 Q -- just because there was no time stamp?

12 A They would have gotten flagged, sir, in the prior  
13 data field that was listed above that, sir.

14 Q They shouldn't be flagged in the same hour  
15 prescribing sale then, correct?

16 MR. ELSNER: Objection.

17 BY MR. KOBRIN:

18 Q They had no hour.

19 A I think if they weren't part of the data set or  
20 didn't have the data to enter the data set, then  
21 they probably would not be recorded, sir. But I  
22 can't comment, that was Dr. McCann's analysis.

23 Q Well, they shouldn't have been in the same hour  
24 prescribing. They should have been in the same day  
25 prescribing because they would have met that

1 requirement, right?

2 MR. ELSNER: Objection.

3 A That would be my assumption as well, sir.

4 BY MR. KOBRIN:

5 Q Turn to page 51 of your report. These bullets on  
6 page 51, they list defendant and stakeholder  
7 policies related to cash payments, right?

8 A I'm sorry, sir, my 51 doesn't have any bullet  
9 points.

10 Q Sorry. They are not actual bullets, but it's  
11 Walmart, CVS, Walgreens, Rite Aid. Do you see  
12 where I'm looking?

13 A Yes, sir.

14 Q I want to focus on the NACDS one, if you could.  
15 It's the last one on that list of stakeholder  
16 policies and it says that -- it states:  
17 "Enforcement actions were nearly 87 percent of a  
18 physician's patients were paid case -- I think it  
19 means paid -- "cash for their prescriptions and  
20 acknowledges that that's a red flag."

21 Do you see that?

22 A I see that in the document, sir, yes.

23 Q Why is that 87 percent data point informative?

24 MR. ELSNER: Objection.

25 A NACDS put that in there and considered it an



1 important reason or an important red flag. From  
2 the perspective of a pharmacy and pharmacist,  
3 whenever a patient pays something for cash, a  
4 prescription or a visit and they have insurance, is  
5 a red flag asking the question, why would they not  
6 submit this to their insurance, and why are they  
7 paying out of their pocket.

8 BY MR. KOBRIN:

9 Q And 87 percent number, that told you something  
10 about the pharmacy and about the prescriber,  
11 correct?

12 MR. ELSNER: Objection.

13 A Again, sir, I apologize. I'm not following the  
14 question.

15 BY MR. KOBRIN:

16 Q These are enforcement actions in which 87 percent  
17 of a physician's patients paid cash for their  
18 prescriptions. That tells you about, in this case  
19 East Main, which I think is a pharmacy, that  
20 there's an enforcement action. It tells you about  
21 the physician for whom 87 percent of his patients  
22 paid cash, right?

23 A Yes, sir.

24 Q It tells you even if the pharmacy in East Main  
25 didn't do a ton of business, let's say that they

1           only dispensed a thousand scripts a day. Too many  
2           of them are paid in cash, right? Would you agree  
3           with that?

4           MR. ELSNER: Objection.

5       A     No, sir. I don't agree with -- maybe I don't  
6           understand the example you're giving.

7       BY MR. KOBRIN:

8       Q     87 percent, that's too high a number for someone to  
9           be dispensing for one physician's patients in cash,  
10          right, or for one pharmacy to be dispensing all of  
11          a product or all of their controls in cash; is that  
12          right?

13      A     NACDS said that. Holiday and East Main said that,  
14          so I would say, I would agree with what that is  
15          saying, sir.

16      Q     That was what I was going to ask. Do you agree  
17          with that?

18               I think it's fair to say that 87 percent of  
19          opioid prescriptions being paid in cash is probably  
20          indicative of diversion, correct?

21      A     I would disagree, sir, and say that one  
22          prescription could be indicative of diversion. The  
23          percentage is not important when it comes to  
24          diversion of a prescription and whether or not that  
25          prescription harms a patient.

1 Q Well, we would expect to see some cash payments,  
2 wouldn't we?

3 A Yes, sir. But we're talking about whether or not  
4 that cash payment was for a legitimate or not a  
5 legitimate prescription. Any prescription that's  
6 not legitimate is diversion and that's concerning  
7 whether it's one or a thousand, sir.

8 Q Right. But you're using this cash fact or -- as a  
9 flag, correct?

10 A As a flag for the pharmacist to conduct due  
11 diligence to ascertain whether or not it was for a  
12 legitimate medical order or not.

13 Q And if you're looking at a pharmacy and the  
14 defendants here are pharmacies, what percentage of  
15 cash payments for prescriptions constitutes an  
16 inappropriate amount? That's what I'm trying to  
17 get at. If you are judging a pharmacy on whether  
18 its dispensed prescriptions are being diverted, I'm  
19 just saying, I think it's fair to say that  
20 87 percent of opioid prescriptions being paid for  
21 in cash is probably indicative of diversion at that  
22 pharmacy.

23 Would you agree with that?

24 A Yes, sir.

25 Q Would you agree that 50 percent of opioid

1 prescriptions being paid for in cash is also  
2 indicative of diversion?

3 MR. ELSNER: Objection.

4 A I think, again, when we're looking at percentages  
5 and the question that came up earlier about what is  
6 significant and what is not, when we're dealing  
7 with prescriptions that are not legitimate, that is  
8 the concern overall; and whether a pharmacy has  
9 50 percent or 87 percent, the fact that there are  
10 patients paying for the prescriptions as a red flag  
11 needs to be resolved.

12 And, then, how much of that pharmacy's  
13 inventory or percentage is information the  
14 corporation has, and that the pharmacy should  
15 receive so the pharmacist could make a better  
16 decision. But as far as I'm concerned, 1 percent  
17 would be significant or one patient if that's not a  
18 legitimate prescription.

19 BY MR. KOBRIN:

20 Q Right. But we're not -- we don't know if that's a  
21 legitimate prescription. We're using this flag to  
22 decide whether we think it's a legitimate  
23 prescription, right?

24 A Correct. And we take each flag individually and  
25 analyze it, and then the pharmacy corporation has

1 to provide data to conduct the larger analysis as  
2 to what those percentages might be and whether or  
3 not those percentages should be included in the  
4 discussion or determination of the pharmacists.

5 Q So you have no opinion either way whether there's a  
6 certain number of a prescriptions at a pharmacy  
7 that would be an acceptable level of cash payments  
8 for opioid prescriptions?

9 A My testimony is that cash payments is a red flag  
10 and that a pharmacy has to evaluate those cash  
11 prescriptions.

12 Q But we've already established that a certain number  
13 you expect would be paid for in cash, I believe you  
14 yesterday you that generally only 87 to 90 percent  
15 of prescriptions are covered by some form of  
16 insurance, correct?

17 MR. ELSNER: Objection.

18 (Stenographer requested clarification.)

19 A Yes.

20 BY MR. KOBRIN:

21 Q You have no opinion as to whether a certain  
22 percentage would be an acceptable percentage of  
23 cash payments in order to assess the dispensing  
24 from a particular pharmacy?

25 MR. ELSNER: Objection.

1       A     My opinion is that that is one of the factors that  
2             the pharmacist looks at to determine whether it's a  
3             legitimate prescription. But the percentage  
4             whether it's 10 percent, 20 percent, 80 percent,  
5             90 percent, is secondary to the fact that the  
6             pharmacist and the corporation make a determination  
7             as to whether or not that's a legitimate  
8             prescription.

9       BY MR. KOBRIN:

10      Q     What about the fact that you're looking at the  
11             number of cash prescriptions in an aggregate? Does  
12             they tell you anything about the defendants in this  
13             case? Shouldn't we be looking at all of these  
14             individually? You're looking at them in aggregate,  
15             correct?

16      A     Yes, sir. What I've commented or testified before  
17             is that absent that documentation that would help  
18             me realize which prescriptions actually had red  
19             flags that were resolved or not, the aggregate data  
20             is important to identify that there was a pattern  
21             occurring and something that warranted concern  
22             because of the number of prescriptions and the  
23             number of opioids that were being distributed, sir.

24      Q     But you could assess the whole prescription? You  
25             have all the information about the prescription.

1           Short of some PHI, you have the dispensing -- you  
2           have the dispensing pharmacist's name, you have the  
3           prescriber's name, you are have the dosage amount.  
4           You have all that information. Why can't you make  
5           the assessment?

6                   MR. ELSNER: Objection.

7           BY MR. KOBRIN:

8           Q       Why are you only dealing with this in aggregate?

9                   MR. ELSNER: Objection.

10          A       The only data I received in that regard were sample  
11           data from the individual defendants, but I did not  
12           look at the entire prescription database.

13          BY MR. KOBRIN:

14          Q       So you're saying that you can't judge the percent  
15           of prescriptions for any particular opioid that  
16           were paid for in cash because every prescription  
17           has to be looked at individually, correct?

18                   MR. ELSNER: Objection.

19          A       Let me explain and see if I understand the question  
20           correctly, sir.

21                   What I'm saying is that the percentages of the  
22           red flags that each of the defendants had in regard  
23           to what is significant or how many of those were  
24           actually red flags, I don't have that  
25           information -- I don't have that information absent

1 documentation.

2 And as far as I'm concerned in my opinion, the  
3 percentage is less important and not as important  
4 as the fact that the red flags existed and the red  
5 flags were resolved, whether that's 1 percent or  
6 99 percent. The opinion is any red flag, any  
7 prescription with red flags should not have been  
8 dispensed by the defendants.

9 BY MR. KOBRIN:

10 Q But you said you need to look at each one  
11 individually, correct? You need to look at each  
12 prescription individually?

13 A In order to substantiate some of the questions that  
14 you're asking about the actual percentages and the  
15 actual number of prescriptions that were legitimate  
16 or not.

17 Q Well, you listed these pharmacies and I'm saying  
18 I'd like to ask for a particular brick and mortar  
19 pharmacy. What percentage of cash prescriptions  
20 would be an acceptable amount to be paid in cash?  
21 And you're saying you have no opinion about that  
22 because things need to be analyzed individually,  
23 correct?

24 MR. ELSNER: Objection.

25 A I think you're asking two different questions and



1 I'll respond to both of them as I understand  
2 them --

3 BY MR. KOBRIN:

4 Q I'm only asking one, sir, if you can answer my  
5 question.

6 A Sure.

7 The industry --

8 Q I'm saying --

9 A -- industry data says that the average pharmacists  
10 and average pharmacy, that 95 percent of the  
11 prescriptions processed are covered by insurance.  
12 That's what my testimony is.

13 I'm not saying what percentage that a pharmacy  
14 that processes cash would be determined to be  
15 diversion or not legitimate. Because pharmacies  
16 could process 10 percent of the prescriptions that  
17 are cash, and those 10 percent could all be  
18 diverted or not for legitimate purpose as well.

19 Q And they could all be perfectly acceptable and for  
20 legitimate purposes as well, correct?

21 MR. ELSNER: Objection.

22 A Correct, sir. That's why the percentage is there  
23 as a guide and that's why it's important to look at  
24 all the information.

25 MS. ZINMASTER: If I may just interject

1 quickly. Tara lost -- Ms. Fumerton lost audio.

2 Can we go off the record for just a moment?

3 THE VIDEOGRAPHER: We're going off the record  
4 at 12:26 p.m.

5 (A recess was taken.)

6 THE VIDEOGRAPHER: We're going back on the  
7 record at 12:29 p.m.

8 MR. KOBRIN: I am going to pass the witness  
9 and if we have time remaining, I have a couple more  
10 questions. Thanks.

11 MR. ELSNER: Dr. Catizone, I've got -- do you  
12 have another --

13 MR. KOBRIN: No, I'm sorry. I meant pass it  
14 to Ms. Fumerton. She's the next questioner.

15 MR. ELSNER: Oh, I'm sorry.

16 MS. FUMERTON: Yes. I'm going to --

17 MR. ELSNER: That was important to get her  
18 back online.

19 MR. KOBRIN: That was why, we had to get her  
20 back on.

21 MR. ELSNER: I was right.

22 MR. KOBRIN: I'm sorry. I assumed that you  
23 got that because you were doing it. Right?

24

25

1 REDIRECT EXAMINATION

2 QUESTIONS BY TARA FUMERTON:

3 Q Thank you, Josh, and thank you, Mr. Catizone.

4 I'm going to be very brief and so I'm going to  
5 ask a series of yes-or-no questions, if you can  
6 keep to that, we'll be even briefer.

7 Mr. Swanson, this morning, asked you questions  
8 about blanket refusals to fill policies, correct?

9 A Yes.

10 Q You understood that Walmart pharmacists have always  
11 had the ability to refuse to fill any prescription  
12 that they felt was inappropriate for any reason,  
13 correct?

14 MR. ELSNER: Objection.

15 A Yes.

16 BY MS. FUMERTON:

17 Q And that meant that Walmart pharmacists could  
18 exercise their professional judgment and not fill a  
19 single prescription from a prescriber they felt was  
20 problematic, correct?

21 MR. ELSNER: Objection.

22 A That's my understanding, yes.

23 BY MS. FUMERTON:

24 Q And Walmart, through its evolution of policies,  
25 also began permitting its pharmacists to blanket

1           refuse to fill a prescription from certain doctors,  
2           correct?

3           A     That, I'm not aware of.

4           Q     Okay. Well, are you aware that at Walmart the  
5           blanket refuse to fill a prescription is a decision  
6           that is made by a single pharmacist in their  
7           professional judgment to not fill any prescriptions  
8           from a particular prescriber without looking at  
9           that individual prescription?

10           MR. ELSNER: Objection.

11          A     That's not my understanding, but I thought you just  
12           mentioned earlier that Walmart permitted its  
13           pharmacists to do that. So it would seem that that  
14           decision was made based with Walmart's approval.  
15           So the corporation approved or allowed pharmacists  
16           to do that rather than the pharmacists exercising  
17           independent judgment. But I'm not familiar with  
18           that.

19          BY MS. FUMERTON:

20          Q     So regardless, you understood that at any given  
21           time if a Walmart pharmacist didn't want to fill a  
22           prescription from a particular prescriber for a  
23           particular reason, they didn't have to do so,  
24           right?

25          A     As long as the reason was justified, yes.

1 Q Are you familiar that Walmart, through its  
2 evolution of policies, began centrally blocking  
3 prescribers?

4 MR. ELSNER: Objection.

5 A No, I'm not familiar with that.

6 BY MS. FUMERTON:

7 Q Okay. You did not read the deposition of Walmart's  
8 corporate representative Sussane Hiland in this  
9 case, correct?

10 A I can't recall specifically if I did or not. I  
11 know I did read depositions from Walmart, but I  
12 can't recall that one specifically.

13 Q Do you know Ms. Hiland?

14 A Yes, I do.

15 Q Do you have a favorable opinion of her?

16 MR. ELSNER: Objection.

17 A I don't have an opinion one way or the other. I've  
18 worked with her professionally, but don't have an  
19 opinion.

20 BY MS. FUMERTON:

21 Q And you always found her to be professional,  
22 correct?

23 A In my professional interactions and all of our  
24 discussions we were always at the professional  
25 level, and I found them to be professional, yes.

1 Q Are you aware that Ms. Hiland testified that  
2 Walmart associates had conversations with various  
3 boards of pharmacies where those boards took the  
4 position that it would be inappropriate for a  
5 retail chain pharmacy to centrally block a  
6 prescriber?

7 MR. ELSNER: Objection.

8 A I don't recall the deposition, but I do know that  
9 that were -- that issue was raised, but I'm not  
10 sure because of the blanket refusal to -- for one  
11 physician. It was based upon the fact that the  
12 entire practice was going to be a blanket refusal  
13 and boards of pharmacy had issues with that rather  
14 than dealing with an individual prescriber based on  
15 information the pharmacy may have.

16 BY MS. FUMERTON:

17 Q And so I just want to make sure the record is clear  
18 and we're not talking past each other. So in the  
19 blanket refuse to fill, it's a pharmacist who is  
20 making the decision not to fill any particular  
21 prescriptions from a particular prescriber,  
22 correct?

23 MR. ELSNER: Objection.

24 A That would be my understanding, but you're  
25 referring to Walmart having a blanket policy and

1 Walmart, so you're suggesting that the corporation  
2 made that decision rather than the pharmacist's  
3 independent judgment.

4 BY MS. FUMERTON:

5 Q So what I'm distinguishing between is the  
6 pharmacist's decision and then also a corporate  
7 block policy or sometimes referred to as the  
8 "central block policy" where the corporate entity  
9 at home office would make a decision that none of  
10 its pharmacists nationwide could fill for a  
11 particular prescriber.

12 Are you familiar with that concept?

13 A I'm not familiar, but I don't understand how that  
14 central policy that impacts the pharmacist's  
15 individual judgment.

16 Q That's not my question.

17 Are you familiar with the concept of a  
18 centrally blocked prescriber?

19 A No, I'm not.

20 Q But you are aware that various boards of pharmacies  
21 have concerns about the home office making a  
22 decision for the pharmacist as to whether or not  
23 the pharmacists could fill a prescription, correct?

24 MR. ELSNER: Objection.

25 A That's not my understanding, no.

1 BY MS. FUMERTON:

2 Q Well, earlier you just testified that you knew that  
3 there were discussions at the boards of pharmacy  
4 about this, correct?

5 A Correct.

6 Q Are you aware that the Wisconsin pharmacy board has  
7 issued an administrative warning to Walmart citing  
8 evidence of professional misconduct because  
9 Walmart's corporate block policies were deterring  
10 pharmacists from exercising their independent  
11 clinic judgment?

12 MR. ELSNER: Objection.

13 A I'm aware of the case, but I think there was more  
14 to it than that.

15 BY MS. FUMERTON:

16 Q Are you aware that the Idaho board --

17 MR. ELSNER: Ms. Fumerton, you're out of time.

18 BY MS. FUMERTON:

19 Q Are you aware that the Idaho board --

20 MS. FUMERTON: I'm sorry?

21 MR. ELSNER: The time period has expired.

22 I've given you another minute of latitude, but the  
23 time is now expired.

24 MS. FUMERTON: Are you not going to let me ask  
25 some more -- another question?



1 MR. ELSNER: I'll let you finish the question  
2 you started, but you've already exceeded your time,  
3 so you can ask about the Idaho board if you want.  
4 But I'm not going to let you continue down this  
5 line of inquiry unlimited. You've already used  
6 your ten hours.

7 MS. FUMERTON: All right.

8 BY MS. FUMERTON:

9 Q Are you aware, Mr. Catizone, that the Idaho Board  
10 of Pharmacy has also stated that Walmart's  
11 directive that certain doctors cannot have -- that  
12 Walmart's directive that certain doctors cannot  
13 have controlled substance prescriptions filled at  
14 Walmart pharmacies and, thereby, not allowing  
15 pharmacists to determine what constitutes a valid  
16 prescription is preventing pharmacists from  
17 fulfilling their legal obligations as a pharmacist  
18 from exercising their obligation of corresponding  
19 responsibility, which violates 21 CFR 1306.04A?

20 MR. ELSNER: Objection.

21 A I'm familiar with that.

22 MS. FUMERTON: So I would --

23 (Simultaneous conversation.)

24 MS. FUMERTON: -- counsel were prohibited  
25 from -- defendants from asking any further

1 questions at this point in time. I'd like to lodge  
2 an objection to the ten-hour limit that was imposed  
3 on the pharmacists -- on the pharmacy defendants,  
4 given that this is a new expert with an  
5 over-100-page report, and five defendants who all  
6 had questions that I know they were not able to  
7 ask, so...

8 MR. KOBRIN: Yeah. I'd like to specifically  
9 lodge an objection on behalf of Giant Eagle. We  
10 did not have enough time to ask the questions that  
11 we had prepared for today. Mr. Elsner, you won't  
12 let me go back and ask the remaining questions that  
13 I have?

14 MR. ELSNER: No, I won't. This is an order  
15 from Judge Polster with respect to the time, and  
16 you've had ample time to ask questions. If you  
17 didn't divide your time equally among counsel, I'm  
18 sorry. That's not my issue or Mr. Catizone's.

19 MR. KOBRIN: You're not --

20 SPECIAL MASTER COHEN: Your objections are all  
21 noted for the record, and I've also observed, Josh,  
22 that you are very good at interrupting the deponent  
23 but you're even interrupting cocounsel, and I  
24 really urge you to watch that. You've been  
25 stepping on Tara this whole time.

1           If you go back and look at the transcript,  
2           you'll see that you're interrupting her more than  
3           once.

4           So I think that brings things to an end.

5           MR. GISLESON: Rite Aid shares that objection  
6           as well. I would have asked more questions had the  
7           parties been given more time. The ten hours was  
8           inadequate.

9           MR. ELSNER: I'm sure every lawyer feels that  
10          way about every deposition. I would like to just  
11          pause for a minute, I want to make sure there's no  
12          issues that we want to clean up in redirect and  
13          I'll just go off the record. I should be able to  
14          do that in one or two minutes.

15          MS. FUMERTON: Okay. We'll come back.

16          THE VIDEOGRAPHER: We're going off record at  
17          12:38 p.m.

18          (A recess was taken.)

19          THE VIDEOGRAPHER: We're going back on the  
20          record at 12:43 p.m.

21          CROSS-EXAMINATION

22          QUESTIONS BY MICHAEL ELSNER:

23          Q     Mr. Catizone, will you please explain to us what  
24          the importance or significance is --

25          MS. FUMERTON: So Mike --

1 MR. ELSNER: Excuse me?

2 MS. FUMERTON: So Mike, you are asking  
3 questions? I thought we were going back to find  
4 out if you are. I'm trying to understand what's  
5 happening.

6 MR. ELSNER: I have maybe three questions to  
7 ask. Very brief.

8 MS. FUMERTON: Okay. Thank you.

9 MR. ELSNER: Sorry about that.

10 BY MR. ELSNER:

11 Q Mr. Catizone, I'm Michael Elsner from the law firm  
12 of Motley Rice on behalf of the plaintiffs. I'm  
13 just going to ask you just a few brief questions  
14 this afternoon.

15 Mr. Catizone, what is the importance or  
16 significance, if any, to a single opioid  
17 prescription that presents with a red flag?

18 A The significance of that is that medication is a  
19 very dangerous and harmful medication, and if that  
20 red flag is not resolved, and those medications go  
21 outside of the system, are diverted, or abused,  
22 that patient harm could occur and does occur.

23 Q So is it your testimony that every single red flag  
24 prescription must be resolved before it is  
25 dispensed?

1       A     My opinion, and also information that's been  
2             conveyed to pharmacists by the DEA and boards of  
3             pharmacy as well.

4       Q     And what must be done in your opinion with respect  
5             to each red flagged opioid prescription?

6       A     The red flag needs to be resolved --

7             MS. FUMERTON: Object to form.

8       A     The red flag needs to be resolved so that the  
9             pharmacist is assured that the prescription is for  
10            a legitimate medical purpose and that it won't  
11            create harm to the patient.

12       BY MR. ELSNER:

13       Q     And does the resolution of that red flag need to be  
14             documented in any way?

15       A     Yes.

16             MR. SWANSON: Objection.

17       BY MR. ELSNER:

18       Q     What was the answer?

19       A     Yes, it does.

20       Q     And how many of those red flag prescriptions must  
21             be resolved and also documented?

22             MS. FUMERTON: Objection; form.

23       A     Any prescription with a red flag must be resolved  
24             and documented.

25       BY MR. ELSNER:

1 Q Okay. So when you testified earlier that it would  
2 be generally significant of 70, 80 percent of red  
3 flag opioid prescriptions did not have  
4 documentation, was that correct?

5 A No.

6 MR. SWANSON: Object to form. Misstates his  
7 testimony.

8 BY MR. ELSNER:

9 Q What percentage of red flag opioid prescriptions in  
10 your opinion must be resolved and documented under  
11 the Controlled Substances Act, the Ohio Board of  
12 Pharmacy rules, and general pharmacy practice?

13 A 100 percent.

14 MS. FUMERTON: Objection; form.

15 MR. ELSNER: I pass the witness.

16 THE WITNESS: I'm sorry?

17 MR. ELSNER: I don't have any further  
18 questions.

19 MS. FUMERTON: Are we off the record?

20 THE VIDEOGRAPHER: We're going off the record  
21 at 12:45 p.m.

22 (A recess was taken.)

23 THE VIDEOGRAPHER: We're going back on the  
24 record at 12:49 p.m.

25 BY MR. GISLESON:

1 Q Mr. Catizone, it's John Gisleson again for Rite  
2 Aid.

3 You just testified that a red flag needs to be  
4 resolved so that the pharmacist is assured that the  
5 prescription is for a legitimate medical purpose  
6 and that it won't create harm to the patient.

7 Can you identify a single patient among the  
8 aggregate data you identified who, in fact, was  
9 harmed as a result in your view of a pharmacist for  
10 one of the chain pharmacies not resolving a red  
11 flag?

12 MR. ELSNER: Objection.

13 A Mr. Gisleson, I can't say that to a specific  
14 prescription, but I could say the overall aggregate  
15 data in opioid overdoses and deaths would indicate  
16 that there were patients that were harmed and  
17 actually died from those prescriptions dispensed.

18 BY MR. GISLESON:

19 Q As an expert in this case, you made no effort to  
20 identify a specific patient, included among the  
21 aggregate data, who, in fact, was harmed, correct?

22 MR. ELSNER: Objection.

23 A I did not perform any analysis to that extent, sir.

24 BY MR. GISLESON:

25 Q So that when you're asked under oath at trial,

1 based on your review of aggregate data, if you can  
2 identify a single patient in Lake or Trumbull  
3 County among your flagged prescriptions, who, in  
4 fact, was harmed, your answer will be no, correct?

5 MR. ELSNER: Objection.

6 A If that question is asked, then that would be my  
7 answer.

8 MR. GISLESON: Those are the questions I have.  
9 Josh?

10 RECROSS-EXAMINATION

11 QUESTIONS BY JOSHUA KOBRIN:

12 Q Returning to the red flags you were just testifying  
13 about on redirect, why did you choose a distance of  
14 25 miles as a red flag metric for the distance  
15 patients traveled to visit a prescriber?

16 MR. ELSNER: Objection; it's beyond the scope.

17 SPECIAL MASTER COHEN: That's sustained.

18 MR. KOBRIN: So you're not going to allow me  
19 to ask that question, Special Master Cohen?

20 SPECIAL MASTER COHEN: Right. That's  
21 something that you delved into before and was not  
22 asked by Mr. Elsner during the last go-around.

23 MR. KOBRIN: I'm sorry. That I delved into  
24 before or just that defendants did?

25 SPECIAL MASTER COHEN: It's beyond the scope



1 of Mr. Elsner's questioning.

2 MR. KOBRIN: Anyone want to ask him any other  
3 questions for the defense that they want to ask  
4 that are within the scope?

5 We pass then.

6 MR. ELSNER: Thank you very much.

7 MS. FUMERTON: And I just -- I think this is  
8 on the record --

9 MR. ELSNER: Can we go off the record? I  
10 think the deposition is closed at this point.

11 THE VIDEOGRAPHER: We are going off the record  
12 at 12:52 p.m.

13

14 FURTHER THE DEPONENT SAITH NOT

15

16

17

18

---

CARMEN A. CATIZONE, MS, RPh, DPh

19

20

21

22

23

24

25

STATE OF INDIANA )  
 ) SS:

2 COUNTY OF HAMILTON )

4 I, Amy Doman, Stenographic Reporter,  
5 Registered Merit Reporter, Certified Realtime  
6 Reporter, Certified Shorthand Reporter, Notary  
7 Public in and for the County of Hamilton, State  
8 of Indiana, at Large, do hereby certify that  
9 CARMEN A. CATIZONE, MS, RPh, DPh, the deponent  
10 herein, was by me first remotely duly sworn to  
11 tell the truth, the whole truth, and nothing but  
12 the truth in the aforementioned matter;

13                   That the foregoing deposition was taken on  
14                   behalf of the Defendants, in Mount Pleasant, South  
15                   Carolina, on Wednesday, June 16, 2021, pursuant to  
16                   the Federal Rules of Civil Procedure;

17           That said deposition was taken down in  
18           stenographic notes and afterwards reduced to  
19           typewriting under my direction, and that the  
20           typewritten transcript is a true record of the  
21           testimony given by the said deponent; and that  
22           signature was requested by the deponent and all  
23           parties present;

24           That the parties were represented by their  
25           counsel as aforementioned.

1 I do further certify that I am a disinterested  
2 person in this cause of action, that I am not a  
3 relative or attorney of either party or otherwise  
4 interested in the event of this action, and that I  
5 am not in the employ of the attorneys for any  
6 party.

7 IN WITNESS WHEREOF, I have hereunto set my  
8 hand and affixed my notarial seal this 21st day  
9 of June, 2021.

10  
11  
12   
13

14 Amy Doman, RMR, CRR, CSR

15 Stenographic Reporter

16 Notary Public  
17  
18

19 My Commission Expires:

20 September 30, 2025,

21 Residing in Hamilton County, Indiana  
22  
23  
24  
25

Veritext Legal Solutions  
1100 Superior Ave  
Suite 1820  
Cleveland, Ohio 44114  
Phone: 216-523-1313

June 21, 2021

To: Michael E. Elsner

Case Name: National Prescription Opiate Litigation - Track 3 v.

Veritext Reference Number: 4628785

Carmen A. Catizone, MS, RPh, DPh Deposition Date: 6/16/2021

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to [production-midwest@veritext.com](mailto:production-midwest@veritext.com).

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,  
Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW  
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 4628785  
CASE NAME: National Prescription Opiate Litigation - Track 3  
DATE OF DEPOSITION: 6/16/2021  
WITNESS' NAME: Carmen A. Catizone, MS, RPh, DPh

In accordance with the Rules of Civil  
Procedure, I have read the entire transcript of  
my testimony or it has been read to me.

I have made no changes to the testimony  
as transcribed by the court reporter.

\_\_\_\_\_  
Date Carmen A. Catizone, MS, RPh, DPh  
Sworn to and subscribed before me, a  
Notary Public in and for the State and County,  
the referenced witness did personally appear  
and acknowledge that:

They have read the transcript;  
They signed the foregoing Sworn  
Statement; and  
Their execution of this Statement is of  
their free act and deed.

I have affixed my name and official seal  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Commission Expiration Date

DEPOSITION REVIEW  
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 4628785

CASE NAME: National Prescription Opiate Litigation - Track 3

DATE OF DEPOSITION: 6/16/2021

WITNESS' NAME: Carmen A. Catizone, MS, RPh, DPh

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

\_\_\_\_\_  
Date Carmen A. Catizone, MS, RPh, DPh

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;  
They have listed all of their corrections in the appended Errata Sheet;  
They signed the foregoing Sworn Statement; and  
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Commission Expiration Date

## ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 4628785

PAGE/LINE (S)	CHANGE	/REASON
---------------	--------	---------

Date Carmen A. Catizone, MS, RPh, DPh

SUBSCRIBED AND SWORN TO BEFORE ME THIS

DAY OF \_\_\_\_\_, 20\_\_\_\_.

Notary Public

Commission Expiration Date

[&amp; - 37,066]

Page 1

<b>&amp;</b>	<b>1306.07</b> 357:14	508:4 531:16	<b>240</b> 392:1
<b>&amp;</b> 344:9 345:3,16	<b>14</b> 397:21 398:8,17 400:11	532:22 533:22	<b>2440</b> 344:17
<b>0</b>	<b>140</b> 428:20	<b>20036-5807</b> 344:21	<b>24400</b> 346:11
<b>014</b> 347:15 363:13	<b>15</b> 402:2 459:13	<b>2004</b> 359:17	<b>25</b> 353:24 354:1 399:3,7,12 413:19 526:14
<b>06</b> 353:16	<b>15219</b> 345:5	<b>2006</b> 413:24 426:24 429:18 436:16 453:19	<b>269-4335</b> 345:10
<b>08</b> 373:16	<b>15219-2514</b> 345:13	<b>2008</b> 486:6	<b>28</b> 344:5 431:17
<b>1</b>	<b>16</b> 343:17 347:15 363:7,8,13,19 365:1 400:2,5,25 401:24 402:3,4 412:23 528:15	<b>2009</b> 457:12,20	<b>2804</b> 343:3,3 348:8
<b>1</b> 348:3 506:16 510:5	<b>16th</b> 348:3 390:9 467:1	<b>2010</b> 465:25	<b>29464</b> 344:6
<b>10</b> 350:6,8,13 390:13 397:7 417:16 418:6 508:4 511:16,17	<b>17</b> 343:3 347:17 348:8 373:19,20 374:8 377:4	<b>2011</b> 347:17 374:1 376:5 465:1,23,25 466:3	<b>3</b>
<b>100</b> 344:16 520:5 524:13	<b>1700</b> 344:11	<b>2014</b> 364:5	<b>3</b> 380:24 397:8,11 466:24 477:1 530:6 531:3 532:3
<b>1000</b> 344:21	<b>1701</b> 345:17	<b>2015</b> 390:14 465:1 466:5	<b>3/10/2015</b> 347:19
<b>1001</b> 344:10	<b>18</b> 347:19 389:4 390:12 391:5 392:14,25 478:24 479:2 481:8	<b>2017</b> 382:9	<b>30</b> 359:12 399:15 417:17 418:6 478:1 483:11,24 484:7,15,17 485:1 485:13 529:20
<b>10:32</b> 466:22	<b>1800</b> 344:20	<b>202</b> 344:22	<b>300</b> 346:11
<b>10:48</b> 467:2	<b>1801</b> 345:22	<b>2020</b> 413:24 426:24 429:18 453:20	<b>303</b> 345:24
<b>1100</b> 530:1	<b>1820</b> 530:2	<b>2021</b> 343:17 348:3 390:9 467:1,7 484:4 528:15 529:9 530:4	<b>312</b> 345:10
<b>11:12</b> 491:13	<b>19</b> 363:2,3 467:7	<b>2025</b> 529:20	<b>316</b> 346:3
<b>11:58</b> 491:16	<b>19-1-9</b> 363:2	<b>205</b> 346:4	<b>32502</b> 346:4
<b>1200</b> 345:23	<b>19103-2921</b> 345:18	<b>21</b> 519:19 530:4	<b>33</b> 413:11,15
<b>12:03</b> 496:8	<b>1919</b> 363:2	<b>21178</b> 529:13	<b>338-5214</b> 345:6
<b>12:10</b> 496:11	<b>2</b>	<b>21202-1031</b> 344:17	<b>344</b> 347:3
<b>12:26</b> 512:4	<b>2</b> 348:4 349:1 350:6 376:8 380:24 390:7 413:16 420:18 471:15	<b>215</b> 345:18	<b>35</b> 353:9 399:6 468:12 469:7
<b>12:29</b> 512:7	<b>20</b> 399:16 417:17 418:6 476:23 479:3 485:12	<b>216</b> 344:12 346:12	<b>3500</b> 345:9
<b>12:38</b> 521:17		<b>216-523-1313</b> 530:3	<b>359</b> 347:15
<b>12:43</b> 521:20		<b>216-9000</b> 344:6	<b>35th</b> 345:5
<b>12:45</b> 524:21		<b>21st</b> 529:8	<b>369</b> 347:17
<b>12:49</b> 524:24		<b>23</b> 389:3	<b>37</b> 486:17
<b>12:52</b> 527:12		<b>24</b> 436:7	<b>37,000</b> 416:22 418:18
<b>1306.04</b> 353:16,19 354:4,9,19 357:6 372:3			<b>37,066</b> 413:22 414:4,10,16,20 416:3,8,15 417:6 418:1,11 420:17
<b>1306.04.</b> 354:3			
<b>1306.04a</b> 519:19			
<b>1306.06</b> 354:9,20 357:6			



[385 - actual]

Page 2

<b>385</b> 347:19 <b>39</b> 483:10,14 484:1 484:11,20 <b>394-7911</b> 345:14 <b>396-5014</b> 346:4	<b>7</b>	<b>a</b>	<b>accuracy</b> 373:9 <b>accurate</b> 351:24 373:7 <b>acknowledge</b> 531:11 532:16 <b>acknowledges</b> 502:20 <b>act</b> 347:15 352:5 352:10,18 353:17 354:18 355:24 356:13 358:6 363:14 364:5,12 364:15 367:13,16 367:19,20 368:4 368:25 369:3 370:1,4,13,14,15 371:20 373:1 377:24 428:1 441:2 449:22 478:14 479:23 524:11 531:14 532:20 <b>acting</b> 471:8,9 <b>action</b> 380:9 439:13 459:24 503:20 529:2,4 <b>actions</b> 385:14 497:1,8,9,12 502:17 503:16 <b>active</b> 382:12 383:16 <b>activities</b> 431:24 <b>activity</b> 431:7 <b>acton</b> 344:20 <b>acts</b> 362:20 <b>actual</b> 391:21 436:22 443:15 476:12 477:18 481:13,13 484:5 497:15 498:12 499:2 502:10
<b>4</b>	<b>70</b> 418:7,10,16,21 418:24 419:4,19 420:8 421:2 445:7 524:2 <b>77</b> 345:9 <b>778-1800</b> 344:22 <b>78</b> 382:4,6,8	<b>a.m.</b> 343:17 348:2 390:5,10 401:15 401:18 466:22 467:2 491:13,16 <b>aberrant</b> 400:17 400:23 401:7 402:10,18 404:10 404:11 405:20 408:11 <b>ability</b> 378:3 384:8 439:24 449:22 463:22 513:11 <b>able</b> 353:8 361:10 377:16 378:10 388:1 412:7 415:8 420:10 428:23 455:6 520:6 521:13 <b>absent</b> 420:5 451:15 508:17 509:25 <b>abuse</b> 353:8 400:18 401:6 402:9 <b>abused</b> 522:21 <b>abusing</b> 456:11 <b>academics</b> 475:4 <b>academy</b> 391:22 <b>acceptable</b> 404:6 507:7,22 510:20 511:19 <b>access</b> 409:25 427:2,3 429:15 436:3 437:5,8 438:17 449:11 453:16 464:24 <b>accessed</b> 478:3 480:25 <b>accountable</b> 379:7 379:15 381:25	
<b>40</b> 483:25 484:6,11 485:8 <b>410</b> 344:18 <b>412</b> 345:6,14 <b>417</b> 347:4 <b>44114</b> 344:11 530:2 <b>44122</b> 346:11 <b>4500</b> 345:13 <b>46</b> 489:25 <b>4628785</b> 530:7 531:2 532:2 533:2 <b>463</b> 347:6 <b>47</b> 487:4	<b>8</b>		
<b>5</b>	<b>8</b> 366:20 <b>80</b> 418:7,16,22,24 419:4 421:2 445:8 508:4 524:2 <b>80202</b> 345:23 <b>831-0001</b> 346:12 <b>843</b> 344:6 <b>87</b> 502:17,23 503:9 503:16,21 504:8 504:18 505:20 506:9 507:14 <b>8:00</b> 343:17 <b>8:09</b> 348:2 <b>8:59</b> 390:5		
<b>5</b> 367:23 483:9,18 483:22 <b>50</b> 505:25 506:9 <b>500</b> 345:13 <b>509</b> 347:7 <b>51</b> 502:5,6,8 <b>517</b> 347:9 <b>522</b> 347:10 <b>55</b> 457:18 <b>56</b> 457:18,20 <b>592-3197</b> 345:24	<b>9</b>		
<b>6</b>	<b>9</b> 352:1 <b>90</b> 418:8,11 419:19 420:9 507:14 508:5 <b>91</b> 366:15,18,20 <b>92</b> 367:23 <b>949-1159</b> 344:18 <b>95</b> 511:10 <b>963-5328</b> 345:18 <b>9630</b> 365:24 <b>99</b> 510:6 <b>9:07</b> 390:10 <b>9:20</b> 401:15 <b>9:21</b> 401:18		
<b>6/16/2021</b> 530:8 531:3 532:3 <b>600-0114</b> 344:12 <b>60601-1692</b> 345:10			

[actual - appear]

Page 3

510:14,15 <b>added</b> 490:4 <b>adding</b> 497:20 <b>addition</b> 462:12 498:3 <b>additional</b> 398:12 489:18 <b>address</b> 427:25 530:15 <b>addressed</b> 455:20 <b>adequate</b> 462:25 <b>adjudicating</b> 440:23 <b>administering</b> 432:25 <b>administration</b> 475:5 <b>administrative</b> 431:1 518:7 <b>administrators</b> 480:19 481:15 <b>advise</b> 371:13 440:14 <b>advised</b> 465:8 <b>advocate</b> 383:21 386:16 <b>advocated</b> 386:20 387:12,16,22 <b>affirm</b> 449:25 <b>affixed</b> 529:8 531:15 532:21 <b>aforementioned</b> 528:12,25 <b>afternoon</b> 522:14 <b>agency</b> 466:14 <b>aggravated</b> 403:10 <b>aggregate</b> 414:25 415:16,20 416:24 417:22 439:7 454:14,17 464:6 508:11,14,19	509:8 525:8,14,21 526:1 <b>ago</b> 360:18,22 <b>agree</b> 375:3 377:3 378:20,20 379:21 398:19,21 404:1 424:10,13 450:22 451:2 491:10 504:2,5,14,16 505:23,25 <b>agreed</b> 375:10 404:1 <b>agreement</b> 356:25 457:14,24 <b>ahead</b> 375:14 <b>aid</b> 345:15 421:20 421:25 439:5 443:12 450:3,5,8 450:13 458:9 459:11,15,25 460:1,19 461:20 462:1,4,5,7,16 463:8 486:1 494:9 494:15 502:11 521:5 525:2 <b>aid's</b> 437:2,8 443:6 457:12 458:24 459:5,8 462:20 <b>aids</b> 349:7 <b>aimed</b> 474:19 <b>albertsons</b> 360:6 360:15,19 361:14 361:22 362:3,13 371:8 412:2,11 496:14 <b>alert</b> 351:21 361:15,19,23 362:4 366:11 431:6,23 <b>alerting</b> 455:22	<b>alerts</b> 361:7,9 368:8 <b>algorithm</b> 453:2 <b>algorithms</b> 474:18 <b>allege</b> 479:6 <b>alliance</b> 345:20 <b>allow</b> 377:6 382:10 417:21 446:19 526:18 <b>allowed</b> 514:15 <b>allowing</b> 519:14 <b>allows</b> 452:7 <b>ama</b> 394:12,22,23 395:4,8,12 396:7 396:19 <b>amas</b> 394:13 <b>american</b> 391:22 403:5 463:16 <b>amount</b> 416:19,20 446:3,13,13,18,20 460:5,12 462:18 505:16 509:3 510:20 <b>amounts</b> 375:23 <b>ample</b> 520:16 <b>amy</b> 343:14 348:12,16 528:4 529:14 <b>analysis</b> 391:2 421:9 424:17 442:3 448:18 462:20,23 463:2 463:10,14 469:11 476:3 478:11,13 481:6,9,13 489:8,9 489:18,23 492:18 493:10 499:18,24 501:22 507:1 525:23 <b>analyze</b> 447:5 470:13 471:18	478:3 506:25 <b>analyzed</b> 441:21 445:17 494:4 510:22 <b>analyzes</b> 440:16 <b>analyzing</b> 447:9 490:7 <b>ands</b> 400:6 <b>annual</b> 394:12 <b>annually</b> 428:17 <b>answer</b> 356:12,12 356:21,22 357:11 357:22 358:12 367:11 368:24 375:14 378:6 380:12 383:7 388:2 400:3 410:2 411:19 412:9,9 417:10 418:5 421:7 434:20 439:11 442:19 443:9,17 453:22 456:13 461:18,24 469:12,18 471:18 489:2 493:16 497:4 511:4 523:18 526:4,7 <b>answered</b> 357:8,9 368:23 369:23 370:6 411:17 496:19 <b>answering</b> 421:12 493:15 <b>answers</b> 405:6 <b>anybody</b> 430:20 <b>anymore</b> 371:20 <b>apart</b> 443:1 <b>apologize</b> 379:2,3 488:3 503:13 <b>appear</b> 531:11 532:15
--	---	---	--

<b>appearances</b> 345:1 346:1 <b>appeared</b> 407:23 <b>appears</b> 375:17 484:5 489:25 <b>appended</b> 532:11 532:18 <b>apples</b> 486:23,23 <b>application</b> 354:9 <b>applied</b> 483:8,21 485:18,21,25 486:13,20 <b>applies</b> 432:4 <b>apply</b> 382:25 421:7 486:8,17 <b>appreciate</b> 375:11 421:12 <b>approached</b> 394:22 395:4 <b>appropriate</b> 353:1 353:5 356:16 358:11 367:11 369:5,10 370:9,16 378:18 387:23 395:23 429:3 433:21 435:1 437:23 445:21 446:3,13,20 456:25 <b>appropriately</b> 368:5 396:25 432:8,11 433:22 <b>approval</b> 364:9 514:14 <b>approve</b> 428:7,10 440:6 <b>approved</b> 428:12 514:15 <b>approximately</b> 422:2	<b>area</b> 354:11 422:22,25 423:11 423:12,15 <b>areas</b> 392:16 394:3 <b>arena</b> 405:12 <b>article</b> 377:7 478:22,22 479:7,8 479:10,17,17 480:7 481:8,16,19 481:21 <b>articles</b> 479:14 481:25 482:4 <b>ascertain</b> 505:11 <b>ashley</b> 355:11 <b>aside</b> 371:21 382:3 <b>asked</b> 357:8,9 368:23 369:23 370:5 375:10 383:24 384:19 403:1,3 408:3 411:17 412:5 418:13 421:7 453:13 463:19 467:12 469:22 471:25 483:5 490:8 492:6 493:10 496:19 513:7 521:6 525:25 526:6,22 <b>asking</b> 354:24 355:23,25 356:9 369:13,13,14 375:11 376:15 387:2 395:13 396:2 426:8 475:18 481:16 493:17 503:5 510:14,25 511:4 519:25 522:2	<b>asks</b> 378:17 <b>assess</b> 507:23 508:24 <b>assessment</b> 395:16 509:5 <b>assignment</b> 531:2 532:2 533:2 <b>assist</b> 409:5,17 <b>assistant</b> 470:23 <b>assists</b> 477:8 <b>associated</b> 447:10 456:7 <b>associates</b> 516:2 <b>association</b> 347:16 363:15 403:6 463:17 <b>assume</b> 448:16 <b>assumed</b> 512:22 <b>assuming</b> 388:23 <b>assumption</b> 378:1 495:15 502:3 <b>assumptions</b> 378:4 <b>assure</b> 349:23 <b>assured</b> 456:10 523:9 525:4 <b>attached</b> 532:7 <b>attaches</b> 390:15 <b>attention</b> 389:9 <b>attorney</b> 441:4 529:3 <b>attorneys</b> 395:9 491:25 492:4 529:5 <b>audio</b> 512:1 <b>audit</b> 350:25 351:12 <b>august</b> 347:15 363:13 <b>authorities</b> 455:22 <b>authority</b> 386:22 447:21 466:14	<b>authorize</b> 532:11 <b>automated</b> 365:11 366:4,10,15,21,24 367:25 368:2 441:5 <b>available</b> 368:10 389:21 410:12,16 411:2 415:11 440:21 441:7,7 447:1 449:13 450:1,10 452:25 499:14 <b>ave</b> 530:1 <b>avenue</b> 344:10 <b>average</b> 441:11,15 511:9,10 <b>aware</b> 361:17 370:19 436:7 441:14,19 445:16 448:6,19 452:6 464:20 468:15 498:21 514:3,4 516:1 517:20 518:6,13,16,19 519:9 <b>awareness</b> 371:1
<b>b</b>			
<b>b</b> 344:20 476:24 <b>back</b> 350:8 352:1 376:4 384:22 385:13 388:17 390:9 393:23 401:17,21 419:9 438:15 459:23 467:1 488:12 491:15 493:11 496:10 512:6,18 512:20 520:12 521:1,15,19 522:3 524:23 530:15			

[background - brian.swanson]

Page 5

<b>background</b> 481:12 <b>balance</b> 397:1 <b>baltimore</b> 344:17 <b>bartlit</b> 345:21 <b>bartlitbeck.com</b> 345:24 <b>base</b> 487:12 501:3 <b>based</b> 354:10 380:3 383:3,18 384:9 385:6 416:18,18,20,22 417:10,11 420:21 433:6,12 435:8 439:7 443:6 445:15 446:1 450:10 452:1,9 454:13,17,18 464:6 469:23 471:24 472:2 478:6,9,13,14 479:21 481:13 484:18 514:14 516:11,14 526:1 <b>basic</b> 399:23 430:23 <b>basis</b> 353:11 354:11 355:20 356:13,19 357:12 357:16,23 367:16 369:3 370:18 382:17 383:11 384:23 408:16 444:2 484:17 <b>baylen</b> 346:3 <b>beck</b> 345:21 <b>began</b> 492:14 513:25 515:2 <b>beginning</b> 391:21 465:19	<b>begins</b> 350:14 375:20 378:24 <b>behalf</b> 343:16 344:2,13 345:2,8 345:15,20 520:9 522:12 528:14 <b>behavior</b> 385:8 400:23 408:10,11 408:12 <b>behaviors</b> 400:17 401:7 402:11,19 404:10,11,23 405:4,10,21 <b>believe</b> 365:12 392:25 422:17 427:12 434:16 440:9 446:10 457:5 459:23 461:19 462:9 464:16,20 465:1 466:3,4 467:23 475:18 496:14 507:13 <b>believed</b> 433:8 <b>benzodiazepine</b> 483:9,19,22 484:6 484:21 <b>best</b> 364:16 378:3 417:9 447:24 470:13 <b>better</b> 393:10 429:14 442:18 506:15 <b>beyond</b> 382:2 396:4,21 412:11 417:12,14 420:10 420:14 453:7 465:14 492:20 494:5 499:19 526:16,25	<b>bigger</b> 365:21 <b>bill</b> 433:13,17 <b>bit</b> 358:25 362:17 371:18 372:2 395:3 399:23 <b>blank</b> 349:12 <b>blanket</b> 382:21 383:2,20 384:7,15 386:10,17 387:12 388:4 513:8,25 514:5 516:10,12 516:19,25 <b>blanketly</b> 382:10 386:23 387:2 <b>block</b> 516:5 517:7 517:8 518:9 <b>blocked</b> 450:4,12 517:18 <b>blocking</b> 389:9 515:2 <b>board</b> 347:18 364:8 371:5 373:4 374:1 375:21 376:14,20 377:4 377:21 379:12,21 380:4,8,13 381:20 385:8,11,12 425:20 426:2,6,11 426:14,15 427:20 429:25 430:5,13 430:22,24 432:21 432:22 433:4,7,8 433:17,20 434:1,4 434:8 438:12 439:3,12,14,19,21 440:5,14,14 441:1 447:4,9,15,18,22 447:23 448:2,4 449:9,14,17 451:19 455:22 458:18,23 461:12	461:14,15 464:8 464:17,21,23 465:4,6,9 466:9 475:19 476:8,13 476:14 479:20,25 518:6,16,19 519:3 519:9 524:11 <b>boards</b> 347:16 359:22 363:15 364:17 372:7 427:10 428:19 435:10 439:10 459:12,24 460:2 461:3 462:17 463:20 466:15 475:12 516:3,3,13 517:20 518:3 523:2 <b>bockius</b> 345:16 <b>boots</b> 345:20 <b>boss</b> 462:9 <b>bottle</b> 498:12,24 499:6 <b>bottom</b> 367:24 374:5 457:19 479:2 <b>boulevard</b> 344:5 346:11 <b>box</b> 349:18 494:25 <b>boxes</b> 494:8,13,15 494:19 <b>break</b> 389:15,20 389:22 390:2,2 395:3 <b>breaks</b> 397:14 400:21 <b>brian</b> 345:22 347:3 348:20 365:20 389:13,15 <b>brian.swanson</b> 345:24
---	--	---	---

[brick - check]

Page 6

<b>brick</b> 510:18 <b>bridgeside</b> 344:5 <b>brief</b> 513:4 522:7 522:13 <b>briefe</b> 513:6 <b>briefly</b> 382:5 <b>brings</b> 521:4 <b>broader</b> 358:25 <b>bullet</b> 409:1 502:8 <b>bullets</b> 502:5,10 <b>bunch</b> 402:23 <b>bush</b> 344:16 467:11 475:17 479:20 483:5 <b>business</b> 503:25 <b>but</b> 400:6	<b>carolina</b> 343:16 344:6 376:15 528:15 <b>case</b> 348:8 349:2 358:21 371:3,17 372:1 382:17,17 383:11,11 384:23 384:23 385:15 390:24 391:2 404:22 407:5,13 407:15 408:24 409:13 422:21 423:21 424:17 425:23 426:1,12 433:14 435:18 437:19 441:22 444:22 445:2,21 449:8 453:2,19 454:13 463:3,10 479:24 489:6 499:11 502:18 503:18 508:13 515:9 518:13 525:19 530:6 531:3 532:3 <b>cases</b> 343:7 421:11 438:19 457:2,4 475:8 478:1,2 <b>cash</b> 404:15,24 406:21 502:7,19 503:3,17,22 504:2 504:9,11,19 505:1 505:4,8,15,21 506:1 507:7,9,10 507:13,23 508:11 509:16 510:19,20 511:14,17 <b>category</b> 418:19 437:3 <b>catizone</b> 343:9,14 348:5,21 365:5,23	378:16 380:16 390:8,12 401:20 421:19 466:17,25 467:5 474:4 491:18 496:13 512:11 513:3 519:9 521:23 522:11,15 525:1 527:18 528:9 530:8 531:4,9 532:4,13 533:20 <b>catizone's</b> 520:18 <b>cause</b> 343:3 529:2 <b>ce</b> 427:14 <b>center</b> 478:22 <b>central</b> 517:8,14 <b>centralize</b> 361:4 <b>centrally</b> 515:2 516:5 517:18 <b>centre</b> 345:5 <b>certain</b> 351:22 360:5 375:18 384:19 387:14 413:5 422:3 427:18,19 458:22 462:18 465:2,3,4 477:5 498:1 499:10 507:6,12 507:21 514:1 519:11,12 <b>certainly</b> 387:7 <b>certificate</b> 532:11 <b>certification</b> 531:1 532:1 <b>certified</b> 343:15 343:15 528:5,6 <b>certify</b> 528:8 529:1 <b>cfr</b> 519:19 <b>chagrin</b> 346:11	<b>chain</b> 350:14 360:6 371:2 409:15 410:6 411:15 419:20 421:9 422:14 423:22 424:2,7 425:16 426:16,20 434:17 435:18 437:18 441:23 442:9,12,14,24 443:2 444:21 445:2,10 453:18 454:11 462:24 463:2,9 516:5 525:10 <b>chains</b> 409:22 410:23 422:19 445:6,7 463:16 <b>chair</b> 417:25 418:14 <b>challenges</b> 390:17 393:9 394:3 396:24 403:4 <b>challenging</b> 395:14 <b>chance</b> 458:3 <b>change</b> 471:7,12 471:13 530:13,14 532:8 533:3 <b>changed</b> 498:7 <b>changes</b> 498:9 530:12 531:7 532:7,9 <b>charged</b> 434:9 <b>chart</b> 472:21 485:7 <b>charts</b> 427:18 <b>check</b> 349:20 394:16 395:22 427:23 459:24 465:10,17 482:11
<b>c</b>			
<b>c</b> 344:1 345:22 347:3 348:20 <b>ca</b> 530:25 <b>calculate</b> 446:20 <b>call</b> 350:9 352:8 364:16 391:15 492:20 494:2,3 <b>called</b> 375:22 400:16 452:15 <b>calling</b> 395:21 396:2 <b>calls</b> 376:14 493:24 494:1 <b>capture</b> 470:6 498:2 499:12 <b>care</b> 358:22 399:20 448:12,15 448:17 468:25 <b>carmen</b> 343:9,14 348:4 365:15 390:8 466:25 527:18 528:9 530:8 531:4,9 532:4,13 533:20			



## [checklist - conducting]

Page 7

<b>checklist</b> 386:3 <b>checks</b> 370:20 <b>chicago</b> 345:10 496:15 <b>choose</b> 526:13 <b>chose</b> 467:15 <b>circumstances</b> 395:12 405:13 416:13 456:19 <b>citation</b> 352:11 <b>cite</b> 352:22 385:18 385:20 478:20,20 479:5,7 481:22 482:4,23 <b>cited</b> 390:23 478:21 479:10 481:16,25 482:17 <b>citing</b> 518:7 <b>civil</b> 343:18 528:16 531:5 532:5 <b>claim</b> 356:7 369:20 370:3 407:4,7 409:15,22 410:23 411:15 440:24 <b>claimed</b> 418:2 <b>claiming</b> 407:15 <b>clarification</b> 507:18 <b>clarify</b> 377:18 386:2 413:25 432:19 440:20 474:1 490:9 491:19,23 492:7 <b>clarity</b> 483:20 <b>clauses</b> 473:23 <b>clean</b> 521:12 <b>clear</b> 354:14 375:14 380:25 381:2 410:4 414:3	464:1 516:17 <b>clearance</b> 385:13 <b>cleared</b> 415:14,15 416:2 <b>cleveland</b> 344:11 346:11 414:21 530:2 <b>client</b> 360:24 361:3 <b>clinic</b> 414:21 518:11 <b>clinics</b> 375:22 <b>closed</b> 412:17 419:15,21 527:10 <b>coaching</b> 380:20 <b>coalition</b> 391:13 391:15 <b>cocktail</b> 483:9,18 483:22 486:8 <b>cocktails</b> 483:6 <b>cocounsel</b> 520:23 <b>cohen</b> 346:9,10 390:1 491:8 520:20 526:17,19 526:20,25 <b>cohesive</b> 392:19 <b>collaboration</b> 470:24 <b>colleagues</b> 421:14 <b>collect</b> 498:10 <b>collected</b> 497:1 498:16,19 499:10 <b>colleges</b> 428:20 <b>column</b> 378:23 379:4 <b>combat</b> 388:1 <b>combination</b> 484:21 <b>combinations</b> 455:4	<b>come</b> 521:15 <b>comes</b> 354:12 504:23 <b>coming</b> 476:17 493:5 <b>comment</b> 362:14 371:13 374:15 377:8,13,16 378:3 378:9 382:1,2 438:6 499:19 501:22 <b>commented</b> 508:16 <b>commission</b> 529:19 531:19 532:25 533:25 <b>committee</b> 391:9 391:12,15 480:17 480:18 <b>communicated</b> 433:3 492:1 495:2 496:1 <b>communication</b> 393:8 394:24 396:19 404:4 491:24 <b>communications</b> 433:7 495:22 <b>community</b> 424:12 <b>companies</b> 439:18 <b>company</b> 345:2 388:11 <b>comparing</b> 485:7 <b>comparison</b> 486:23 <b>competencies</b> 432:14 <b>competency</b> 432:17	<b>compilation</b> 427:8 427:16,24 <b>compiled</b> 427:17 <b>compiles</b> 430:21 <b>complaint</b> 459:25 <b>complaints</b> 394:9 <b>complete</b> 375:1,9 375:17,17 376:8 378:24 411:7 430:12 431:9 432:1 <b>completed</b> 530:15 <b>completeness</b> 374:17 <b>compliance</b> 426:7 426:11 458:11 <b>complicated</b> 442:5 442:7 <b>comply</b> 357:21,24 370:14 466:8 <b>complying</b> 380:10 <b>computer</b> 443:6 498:8 <b>concept</b> 517:12,17 <b>concern</b> 433:17 447:19 468:8,19 506:8 508:21 <b>concerned</b> 506:16 510:2 <b>concerning</b> 425:21 461:4 505:6 <b>concerns</b> 448:5 517:21 <b>condition</b> 446:5 <b>conditions</b> 435:12 <b>conduct</b> 399:17 463:22 505:10 507:1 <b>conducted</b> 415:4 <b>conducting</b> 370:20 394:25
--	---	---	--

[confirm - corresponding]

Page 8

<b>confirm</b> 395:22	<b>continue</b> 356:23	<b>convene</b> 394:23	471:10 472:25
<b>confirmed</b> 383:7	374:18 381:8,9,11	395:4	473:21 474:4
<b>confirming</b> 349:17	519:4	<b>conversation</b>	475:13,20 476:10
<b>confused</b> 498:25	<b>continued</b> 345:1	375:12 459:5,8	477:13 481:22
<b>connection</b> 429:2	346:1 347:3	480:3 490:15	482:18,24 483:12
<b>connections</b>	348:19	492:3 495:5	483:24 484:15
493:20	<b>continues</b> 350:23	519:23	485:8 486:1,9,25
<b>consideration</b>	374:25 376:7	<b>conversations</b>	489:15 490:5
435:2	<b>continuing</b> 426:18	433:12 492:17	492:2,8 495:3,8,10
<b>considered</b> 502:25	426:23 427:11,13	493:8,13,21	495:14 496:15
<b>considers</b> 455:10	<b>continuity</b> 468:25	495:24 516:2	498:3 499:8 500:3
<b>consistency</b> 485:6	<b>contribution</b>	<b>conveyed</b> 492:18	500:9,10,17,25
<b>consistently</b> 485:4	364:4,5	523:2	501:1,15 503:11
485:19,22,25	<b>control</b> 353:5	<b>cook</b> 448:15	504:20 505:9
486:8,13,17,21	392:18 447:21	<b>coordinate</b> 392:10	506:24 507:16
<b>constitute</b> 400:22	<b>controlled</b> 351:3	<b>copies</b> 447:16	508:15 509:17
<b>constitutes</b> 398:22	352:4,9,17 353:2,6	<b>copy</b> 352:23,24	510:11,23 511:20
399:24 505:15	353:17 354:18	366:14 428:23	511:22 513:8,13
519:15	355:13,23 356:12	429:10	513:20 514:2
<b>constructed</b> 406:7	358:6,12 369:5	<b>corporate</b> 350:10	515:9,22 516:22
<b>consulting</b> 360:19	375:24 385:5,10	352:1 384:3,3,10	517:23 518:4,5
<b>consumed</b> 445:23	390:18 404:16	460:10 515:8	524:4 525:21
<b>contact</b> 494:5	406:22 411:18	517:6,8 518:9	526:4
<b>contain</b> 438:3	412:16,18 418:23	<b>corporation</b>	<b>corrections</b> 530:12
<b>contained</b> 367:15	419:13,16,22	355:19 388:21,23	532:17
373:7 427:1	424:25 428:1	411:3,4,5 428:22	<b>correctly</b> 376:17
479:18	429:2 431:6,13,23	450:10 460:17	398:10 402:15
<b>container</b> 498:20	432:11 433:10,24	506:14,25 508:6	431:16 457:17
<b>contains</b> 438:7	434:25 441:13,16	514:15 517:1	468:17 487:15
<b>content</b> 351:19	441:24 442:25	<b>correct</b> 353:21	509:20
373:1,2,11,13	452:19 456:1	354:20 374:2	<b>corresponding</b>
374:8 380:7	459:7,16 460:21	378:2 381:15,18	353:20 371:15,17
391:17 392:8,11	465:16 468:11,13	385:14 388:7	372:3 374:22
392:13,16 428:10	476:25 477:5,9	390:24 397:12	375:2 376:10,21
430:4 432:20	478:15,16 480:10	402:8 406:25	379:13,24 380:11
<b>contents</b> 364:19	519:13 524:11	414:8,18 416:5	381:23 387:21
368:2 391:10	<b>controls</b> 353:2	428:12 432:5,12	394:1,5,10 395:2
<b>context</b> 378:18	358:11 369:5	433:4 439:22	396:15 409:6,14
380:3,22	387:23 504:11	440:1 445:14	409:21 410:21
<b>continuation</b>	<b>controversy</b>	446:24 457:25	411:13 438:13
408:23	459:14	467:21,25 470:20	439:6 453:14

## [corresponding - dealing]

Page 9

454:6 456:3 463:6 463:13 519:18 <b>counsel</b> 348:13,15 490:19 491:1 492:14,19,22 493:6,8,11,21,25 495:3,5,10,17,20 519:24 520:17 528:25 <b>counter</b> 358:4 362:5,9 368:20 <b>counties</b> 416:20,21 417:23 420:23 422:11 423:10,16 444:14 445:11,24 446:4,21 448:8,9 448:12 450:6 453:9,24 454:4 462:21 <b>counting</b> 366:7 <b>country</b> 358:16 359:2,5,21,22,24 368:17 411:22 448:16,19 481:15 <b>county</b> 343:16 420:11,13 421:21 421:22,25 422:6 422:13,15,23 423:1,23 424:3,8 425:3,10,22 434:17 439:22 442:25 443:14 444:12,18 445:1 445:20 446:14 448:3,15,21 450:17 451:11 462:24 464:10,13 466:7 526:3 528:2 528:7 529:21 531:10 532:15	<b>couple</b> 357:9 512:9 <b>course</b> 466:13 <b>courses</b> 426:19 <b>court</b> 343:1 348:7 348:11 356:5 363:5 531:7 <b>courtney</b> 344:4 <b>cover</b> 390:13 404:18 406:24 <b>coverage</b> 407:17 <b>covered</b> 507:15 511:11 <b>covering</b> 469:2 <b>covid</b> 361:5 <b>create</b> 351:21 391:17 393:18 434:11,18 470:11 484:20,22 523:11 525:6 <b>created</b> 351:23 391:5,5 459:13 468:20 <b>creating</b> 432:25 <b>creation</b> 392:2 <b>credit</b> 452:21 <b>critical</b> 406:6 432:23 433:9 <b>criticized</b> 403:10 <b>cross</b> 347:3,4,6,9 348:19 421:17 467:3 521:21 <b>crr</b> 529:14 <b>crunching</b> 495:8 495:10 <b>csa</b> 352:12,21,24 354:22,25 355:3,6 357:2,11,15,23 362:6 <b>csr</b> 529:14	<b>cut</b> 401:20 <b>cuts</b> 424:14 <b>cvs</b> 344:13,14,14 344:14,14 439:5 485:25 494:8,14 502:11 <b>cwolf</b> 344:7 <b>d</b> <b>d</b> 345:12 <b>dangerous</b> 522:19 <b>data</b> 350:19 351:7 351:11,15,21 352:19 353:4 354:5,17 355:2 357:3,19 358:3,16 359:2,25 360:6,7 360:12,16 361:19 361:24 362:10 367:1,25 368:18 369:4,9,17 370:10 370:19 388:21 409:4,8 410:7,15 410:16 411:2,4,5 411:18 412:14 413:2,24 414:25 415:17,20 416:24 419:12 420:22 422:8 438:21 439:8 440:17 444:10 445:4,15 446:16 447:1,5,8 449:25,25 450:10 451:15 454:10,14 454:17,18,19,22 457:6,10 464:6 468:1,2,3 469:24 470:13 471:19 472:14 477:6 478:3,4,9 484:5 485:19,22 486:14 486:20 488:12,12	488:13,14,16,17 488:20 489:19,19 490:7,13 492:2,6 492:17 494:4,18 494:19,22 496:25 498:10 499:10,18 499:24 501:13,19 501:20,20 502:23 507:1 508:19 509:10,11 511:9 525:8,15,21 526:1 <b>database</b> 509:12 <b>date</b> 530:8 531:3,9 531:19 532:3,13 532:25 533:20,25 <b>dated</b> 347:19 390:13 <b>dates</b> 465:20 <b>david</b> 345:4 346:9 346:10,12 <b>day</b> 345:8,12 426:1,1 436:7 488:9 500:9,16,22 501:4,24 504:1 529:8 531:16 532:22 533:22 <b>days</b> 436:8 467:20 470:1 483:11,24 484:7,15,17 485:1 485:12,13 530:18 <b>dc</b> 344:21 <b>dea</b> 355:7,11,18 382:12 383:16 385:11 387:18 399:9,18 443:23 451:25 455:22 457:5,8,13,14 475:9 523:2 <b>dea's</b> 393:20 <b>dealing</b> 506:6 509:8 516:14
--	--	--	--



[dear - disagree]

Page 10

<b>dear</b> 530:10 <b>deaths</b> 416:20 417:12,22 420:24 525:15 <b>debatable</b> 399:19 <b>decide</b> 489:4 506:22 <b>decides</b> 406:3 <b>deciding</b> 449:3 <b>decision</b> 384:2 388:25 411:3,7 430:9 447:22 450:1 467:19,23 470:15,15 506:16 514:5,14 516:20 517:2,6,9,22 <b>decisions</b> 395:15 <b>declined</b> 477:6 480:10 <b>decrease</b> 481:1 <b>deed</b> 531:14 532:20 <b>deemed</b> 530:19 <b>defendant</b> 345:8 345:15 369:21 485:13 486:24,24 494:8,14 502:6 <b>defendants</b> 343:16 344:13 345:2,20 356:6 358:21 407:5,15 409:3 422:6,10,15 425:16 426:21 437:14 453:1,1 454:23 485:1,4,20 486:9,18 499:11 499:25 505:14 508:12 509:11,22 510:8 519:25 520:3,5 526:24 528:14	<b>defense</b> 527:3 <b>defer</b> 439:14 <b>define</b> 418:13 475:25 <b>defined</b> 475:5,23 476:2,23 <b>defining</b> 420:7 487:18,21 500:2,4 <b>definition</b> 377:21 393:21 476:7,8,12 476:15,15 <b>definitively</b> 458:3 482:13 <b>degree</b> 364:18 <b>delved</b> 526:21,23 <b>demetra</b> 355:10 <b>demographic</b> 424:14 <b>demographics</b> 424:6,10,13 <b>denver</b> 345:23 <b>department</b> 530:22 <b>depending</b> 424:11 442:3 456:23 <b>deponent</b> 520:22 527:14 528:9,21 528:22 <b>deposed</b> 458:13 <b>deposition</b> 343:9 343:13 347:14 348:4,9 390:8 466:25 467:11 515:7 516:8 521:10 527:10 528:13,17 530:8 530:11 531:1,3 532:1,3 <b>depositions</b> 425:17 515:11	<b>depression</b> 484:23 <b>describe</b> 402:17 427:5 487:5 <b>described</b> 473:14 <b>describes</b> 364:16 <b>describing</b> 393:19 <b>description</b> 472:2 492:1 <b>designated</b> 466:5 <b>desk</b> 349:12 <b>detail</b> 356:19 493:20 <b>detect</b> 393:1 410:17 453:3,3 <b>detecting</b> 477:8 <b>determinant</b> 500:7 <b>determination</b> 388:22 399:15 418:22 420:10 432:22 441:8 452:8 489:12 507:4 508:6 <b>determine</b> 361:8 387:7 415:9 422:22 423:21 428:11 440:16 441:25 442:22 444:19 446:7 451:20 462:25 463:3,10 508:2 519:15 <b>determined</b> 384:25 386:21 399:12 511:14 <b>determining</b> 408:13 431:5,22 <b>deterring</b> 518:9 <b>develop</b> 435:11 <b>developed</b> 432:20 452:14	<b>dictate</b> 372:19 <b>didactic</b> 431:10 432:2 <b>died</b> 420:11 525:17 <b>differ</b> 398:22 399:24 400:5 <b>difference</b> 387:5 418:20 500:21 <b>different</b> 371:12 409:19 412:8,23 434:8 440:19 448:15 455:2 462:12 468:14 470:10 471:9 472:10 478:8 487:11 510:25 <b>diligence</b> 399:17 415:3 460:13 463:23 505:11 <b>direct</b> 368:12 431:14 494:5 495:5 <b>directed</b> 380:5 401:24 <b>direction</b> 528:19 <b>directive</b> 519:11 519:12 <b>directly</b> 492:20 493:5,8,21 496:1 <b>director</b> 391:6 426:6 427:20,23 428:4 433:3,12 435:10 440:12 448:1 449:17 <b>directors</b> 364:8 427:9 461:12 <b>disagree</b> 381:6 399:7 404:24 504:21
--	--	--	--

<b>disconnect</b> 420:2,3	358:3,12,16,18	508:23	<b>division</b> 343:2
<b>discovery</b> 486:6	359:2,4,25 360:1,6	<b>distributing</b> 445:6	348:8 426:5
<b>discuss</b> 391:10	360:7,8,12,14,16	<b>distribution</b>	<b>doctor</b> 377:21
400:14 458:24	360:16,17,22	344:14 353:5	385:10 414:15
491:4	361:2,6,8,12,19,24	358:11 361:4	416:12 467:12,16
<b>discussed</b> 397:5	362:10,12 366:7	369:11 412:18	467:20 468:19
399:19 411:14	367:1 368:18	419:15,21	471:6,16 475:5,13
492:16	369:4,5,9,10,17	<b>district</b> 343:1,1	475:19,23,25
<b>discusses</b> 397:8	370:9,10,16,18	348:7,7	476:4,7,9,12,23
<b>discussing</b> 352:4	371:1 372:15	<b>diversion</b> 350:24	477:4,15,16,18,20
405:24	386:3 388:21	351:3,8 352:19	478:13 479:16,18
<b>discussion</b> 394:2	390:18 396:15	353:8 354:6,17	480:9,23,25 481:3
398:6,9 459:21	401:10 402:14	355:2 357:4,19	481:3,18 482:5,9
462:5,10,11,13,15	409:8 410:7,15,16	358:5,17 359:3,25	<b>doctor's</b> 396:9
480:21 507:4	411:2,4,18 412:18	361:15,20 362:6	397:2
<b>discussions</b> 459:14	413:1,23 419:15	366:12 367:2	<b>doctors</b> 383:15,16
459:22 460:4	419:22 424:18,21	368:19 369:17	394:15 395:24
483:7 515:24	425:8,21 429:2	370:10 383:6,6	414:9 448:7 469:8
518:3	436:20 438:21	388:2 393:2,15,20	469:14 470:6,18
<b>disinterested</b>	439:25 440:6,16	400:19 401:6	514:1 519:11,12
529:1	440:22 441:6	402:10 405:23	<b>document</b> 343:6
<b>dispense</b> 361:25	454:10,14,18,19	409:9 410:18	355:14 363:13,24
368:5 386:5	454:22 458:25	412:15 416:24,25	364:1 368:6
395:15,18 456:1	460:15 464:19	419:13 420:25	373:25 374:17
460:16,16,21	465:16 477:8	440:17 449:6	375:1,5 381:8,9,14
498:2	485:3,12 489:5	452:3,24 453:3	386:5,7 390:13,16
<b>dispensed</b> 416:19	496:17 497:13,19	454:12,13,17,20	390:20,23 391:1,5
417:11 419:20	497:21,24 498:4,6	455:10,19 456:7	391:10,17,21
425:1 445:7,19,23	499:8 504:9,10	456:17 457:6,9	392:3,8,14,19,20
446:11 453:19	507:23 509:1,2	477:10 504:20,22	392:22,25 393:6,7
469:25 483:11,24	<b>distance</b> 399:11	504:24 505:6,21	393:14,19,24
484:7,15 487:10	404:14 408:13	506:2 511:15	394:12 396:25
487:19 499:15	413:17 526:13,14	<b>diverted</b> 417:2	397:7,12 398:3
504:1 505:18	<b>distances</b> 404:23	419:21 420:4	401:25 402:22
510:8 522:25	<b>distinguish</b> 500:13	451:21 452:8	403:16,17,21
525:17	<b>distinguished</b>	505:18 511:18	404:2,6 405:2,3,18
<b>dispensing</b> 350:19	500:8	522:21	405:19,21 406:7,8
351:7,11,12,15,21	<b>distinguishing</b>	<b>diverting</b> 384:25	406:16,25 407:5
352:19 353:4,4	517:5	455:23 456:11	407:20,21,23,24
354:5,17 355:2	<b>distributed</b> 373:23	<b>divide</b> 520:17	407:25 408:4,5,16
356:17 357:3,18	420:12,23 444:12		429:19 430:2

[document - elsner]

Page 12

436:24 441:5 459:6,19,20 461:5 462:6 473:3 481:25 483:3 490:16 502:22 <b>documentation</b> 368:15 406:1,3,6 406:12,14 407:13 408:17 415:7,21 417:19 418:17 420:6,9 430:15 436:6,11,23 444:5 446:7 469:3 508:17 510:1 524:4 <b>documented</b> 404:17 405:25 406:2,11,23 407:16 408:14 416:2 436:2 469:1 471:13 523:14,21 523:24 524:10 <b>documenting</b> 430:11 460:13 <b>documents</b> 349:7 349:24 384:18 399:10 475:23 476:1,6,22 <b>doing</b> 375:23 382:20 393:13 394:6 396:8,14 432:7 464:18 495:7,10 512:23 <b>doman</b> 343:14 348:12 528:4 529:14 <b>dosage</b> 487:13 500:5 501:4,6 509:3 <b>dosages</b> 487:23	<b>doses</b> 446:4 <b>dph</b> 343:9,14 527:18 528:9 530:8 531:4,9 532:4,13 533:20 <b>dr</b> 388:12,15 412:25 413:7,25 473:18 474:6 487:24 488:16 489:4,11,15 490:22 491:25 492:4,25 493:13 493:14 494:6 495:7,12,14,17,20 495:23,24 496:2 501:22 512:11 <b>draft</b> 472:18,20 473:13,17,22 474:3 492:15,22 492:23,25 493:2 495:13 <b>drafter</b> 392:5 <b>drafting</b> 492:14 <b>drafts</b> 364:1 <b>drawing</b> 445:13 <b>drug</b> 367:21,22 369:10,13 370:8 394:20 438:4 444:13 483:6,9,18 483:22 486:7 487:13 496:16 499:14,22 500:4 501:3,6 <b>drugs</b> 465:2,3,4 466:5 484:23 <b>due</b> 399:17 460:13 463:22 505:10 <b>duly</b> 528:10 <b>dunning</b> 346:2 <b>duplicative</b> 455:3 470:11 471:3,10	471:12 <b>dur</b> 370:13,20 394:25 440:24 <b>duties</b> 409:7 <b>e</b> <b>e</b> 344:1,1,3 530:5 <b>eagle</b> 345:2 422:10 422:19 439:6 467:6 486:1 520:9 <b>earlier</b> 388:17 416:18 438:15 449:21 491:23 500:1 506:5 514:12 518:2 524:1 <b>early</b> 465:24 <b>easier</b> 364:24 365:18 <b>easily</b> 405:5 429:15 <b>east</b> 344:10,16 503:19,24 504:13 <b>eastern</b> 343:2 345:20 348:2,8 <b>edited</b> 493:1 <b>editor</b> 372:23 373:1 374:6,6 392:6 430:4 <b>educate</b> 381:17 <b>education</b> 372:9 426:19,23 427:11 427:13 431:10 432:2 <b>educational</b> 434:5 <b>eekhoff</b> 344:5 <b>effort</b> 364:2 442:22 525:19 <b>either</b> 349:7 415:11 421:21 425:9 426:9,10 443:13 455:21	456:7 507:5 529:3 <b>electronic</b> 349:8 349:14 367:24 <b>electronically</b> 368:3,8 <b>element</b> 490:4 <b>elsner</b> 344:3 347:9 352:14 353:14 354:7,21 355:5 356:10 357:8 358:8,19 359:7 360:3,23 361:16 361:21 362:7 364:6 365:2,15,23 367:5 368:23 369:23 370:5 371:4 373:18,21 374:16 375:4,8,13 376:25 377:5,12 377:14 378:13,16 379:18 380:2,14 380:22 381:6 382:22 384:12 386:1,13,19 387:17 388:8,16 389:19,24 391:11 392:9,15 393:3,22 395:25 396:10 397:3,17,24 398:24 399:8 400:1,8 401:13 402:5,25 405:7 406:13 407:1,8 408:8 409:24 410:9,25 411:10 411:17,25 412:4 414:11,17,23 415:6,18 416:4,17 417:8 418:4,25 419:7,23 420:20 421:3,10 422:1,7
--	--	---	---

422:16 423:3,17 423:24 424:20 425:4 426:25 427:7 428:9 429:21 430:16 432:13 433:11,25 434:13,19 435:5 435:14 436:5,19 437:4,11,20 438:5 438:14,23 439:9 440:2,8,18 441:18 442:2,15 443:3 444:9 445:3,25 446:15,25 447:7 448:23 449:10 450:7 451:1,14,23 453:21,25 454:5 454:15,21 455:1 455:14 456:20 457:7 458:1,10 459:2 460:9,22 461:23 464:3 465:13 466:12 468:5,24 469:10 469:16 470:8 471:17,23 472:8 472:17,22 473:6 473:12,19,21 474:8,13,20 475:1 475:6,14 476:20 477:22 479:9 480:11 481:23 482:6,10,19,25 483:16 485:9,14 486:2,10,19 487:1 488:1,7,19,24 489:7,16 490:6,17 491:4 492:9 494:17 495:4 496:19 497:3 498:13,17 499:16	500:11,19 501:9 501:16 502:2,24 503:12 504:4 506:3 507:17,25 509:6,9,18 510:24 511:21 512:11,15 512:17,21 513:14 513:21 514:10 515:4,16 516:7,23 517:24 518:12,17 518:21 519:1,20 520:11,14 521:9 521:22 522:1,6,9 522:10,11 523:12 523:17,25 524:8 524:15,17 525:12 525:22 526:5,16 526:22 527:6,9 530:5 <b>elsner's</b> 527:1 <b>email</b> 347:19 390:13,14 490:16 530:17 <b>emails</b> 495:16,17 495:19 <b>emergency</b> 452:14 <b>employ</b> 529:5 <b>employee</b> 379:9,17 380:1 462:7 <b>employer</b> 379:8,16 379:25 <b>empower</b> 387:24 <b>empowering</b> 388:5,13 <b>enclosed</b> 530:11 <b>encounter</b> 398:4 <b>encroach</b> 396:21 <b>ends</b> 365:24 <b>enforcement</b> 502:17 503:16,20	<b>enforcing</b> 358:10 <b>engage</b> 449:6 <b>ensure</b> 369:9 403:9 432:18 <b>enter</b> 501:20 <b>entered</b> 497:16 532:9 <b>entire</b> 354:22 372:24 374:10 377:7 406:6 426:6 509:12 516:12 531:5 532:5 <b>entirely</b> 370:17 449:18 <b>entirety</b> 354:1 356:13 357:23 408:15 <b>entities</b> 391:20,25 392:1 <b>entitled</b> 488:14 <b>entity</b> 517:8 <b>envelope</b> 373:15 <b>epidemic</b> 424:14 <b>equal</b> 424:15 <b>equally</b> 424:15 520:17 <b>errata</b> 530:13,18 532:7,10,18 533:1 <b>erred</b> 493:15 <b>error</b> 360:17,21 361:11 <b>especially</b> 485:6 <b>essence</b> 395:13 <b>established</b> 380:15 507:12 <b>evaluate</b> 382:16 424:6,25 425:7,8 441:23 507:10 <b>evaluated</b> 464:11 <b>evaluates</b> 464:18	<b>evaluating</b> 434:24 437:25 442:25 <b>evaluation</b> 401:10 402:13 <b>evening</b> 479:22 <b>event</b> 404:5 529:4 <b>events</b> 368:1 369:8 369:8 <b>everybody</b> 363:12 364:24,25 373:19 373:22 <b>evidence</b> 385:15 385:21 444:24 518:8 <b>evolution</b> 513:24 515:2 <b>exact</b> 452:13 <b>exactly</b> 386:6 393:4 398:17 408:16 <b>exam</b> 347:1 432:20,20,25,25 <b>examination</b> 343:13 347:3,4,6,7 347:9,10 348:19 421:17 432:9 467:3 513:1 521:21 526:10 <b>example</b> 363:20 412:5,6 427:21 435:8 504:6 <b>exams</b> 432:15 <b>exceeded</b> 519:2 <b>excellence</b> 478:22 <b>excessive</b> 446:2,11 446:13,18 <b>excuse</b> 371:19 389:5 522:1 <b>executed</b> 532:10 <b>execution</b> 531:14 532:19
---	---	--	---

[executive - find]

Page 14

<b>executive</b> 374:6 391:6 392:6 426:6 427:9,20,22 428:3 430:4 433:2,12 435:9 440:12 448:1 449:16 <b>exercise</b> 383:10 384:8 449:2,22 463:6,13 513:18 <b>exercised</b> 456:24 <b>exercising</b> 379:16 394:19 456:3 514:16 518:10 519:18 <b>exhibit</b> 347:15,17 347:19 349:1 350:6 363:1,5,8,13 363:19 365:1 373:20 374:8 377:4 389:1,4 390:12 391:5 392:14,25 404:12 <b>exhibited</b> 385:7 <b>exhibits</b> 347:13,14 349:11,19 473:2,4 <b>exist</b> 359:10 369:2 401:7 402:11 <b>existed</b> 455:2 510:4 <b>existing</b> 369:2 435:19,24 <b>expect</b> 422:25 423:7,9 424:2 435:8 461:2,6,10 499:21 501:7 505:1 507:13 <b>expectation</b> 486:12 <b>expected</b> 499:18 499:24 501:2	<b>experience</b> 354:10 359:20 371:7 385:6 431:11 432:3 435:9 471:25 476:11 482:14 <b>expert</b> 350:5 478:2 520:4 525:19 <b>expertise</b> 453:13 489:4,8 497:22 <b>expiration</b> 531:19 532:25 533:25 <b>expired</b> 518:21,23 <b>expires</b> 529:19 <b>explain</b> 352:22 367:9 370:7 377:18 474:12 490:10 492:7,11 509:19 521:23 <b>explainable</b> 405:5 <b>explained</b> 354:8 356:15 405:11 468:9 494:2 <b>explanation</b> 367:15 408:14 <b>explicit</b> 500:6 <b>exponentially</b> 452:4 <b>express</b> 370:2 460:20 <b>expressed</b> 377:4 <b>extended</b> 396:4 <b>extensive</b> 462:13 <b>extent</b> 378:9 397:4 435:18 439:17 525:23	<b>fact</b> 380:17 416:22 440:5 443:24 444:14 448:2 453:1 460:2 476:12 480:13 487:22 505:8 506:9 508:5,10 510:4 516:11 525:8,21 526:4 <b>factor</b> 454:7 <b>factors</b> 384:2 400:18 401:5 402:8 424:14 487:21 500:2,4 508:1 <b>facts</b> 456:18 458:5 <b>factually</b> 420:24 <b>failed</b> 409:3 463:25 <b>failure</b> 412:14 419:11 <b>fair</b> 382:3 395:16 396:9 484:13 504:18 505:19 <b>faith</b> 386:2 <b>familiar</b> 363:24 434:21 514:17 515:1,5 517:12,13 517:17 519:21 <b>family</b> 391:23 <b>far</b> 376:14 418:6 506:16 510:2 <b>faster</b> 366:16 <b>fault</b> 382:8,19 <b>favorable</b> 515:15 <b>feature</b> 487:18 <b>federal</b> 343:17 357:20,22 370:15 381:22 528:16 <b>feel</b> 367:11 387:18	<b>feeling</b> 460:14 <b>feels</b> 521:9 <b>fell</b> 418:18 <b>fellow</b> 379:9,17 380:1 <b>felt</b> 385:24 396:4 403:12 513:12,19 <b>field</b> 501:13 <b>files</b> 385:16 <b>fill</b> 382:11,21 383:2,14,20 384:7 385:4,9,16,23 386:10,17,23 387:2,4,10,13 388:4,12 394:14 409:14 410:2 431:5,22 437:25 438:10 441:12,16 449:19,24 455:12 455:25 456:5,25 459:16 460:11 461:20 462:18 472:21 498:23 499:5 513:8,11,18 514:1,5,7,21 516:19,20 517:10 517:23 <b>filled</b> 376:13,24 384:21 438:22 443:14,17,19 444:3 446:18 450:4 519:13 <b>filling</b> 355:14 387:14 447:17 453:9 460:8 463:4 463:12 <b>fills</b> 427:20 <b>final</b> 350:22 364:7 392:7 403:17 <b>find</b> 359:9 484:12 522:3 530:11
	<b>f</b>		
	<b>faced</b> 393:10 403:4 <b>facilitates</b> 432:24		

<b>finding</b> 376:13 <b>fine</b> 348:24 388:20 389:18 <b>finish</b> 413:12 519:1 <b>fired</b> 460:17,20 <b>firm</b> 348:10 349:19 522:11 <b>first</b> 356:3 374:14 374:21 375:6 465:2,8,19 472:23 473:1,1,4,7 492:20 494:2,14 499:17 528:10 <b>firsthand</b> 463:15 <b>fit</b> 392:19 413:23 <b>five</b> 377:22 389:16 422:2,9,18 479:21 520:5 <b>fl</b> 346:4 <b>flag</b> 369:19 390:17 392:2 398:22 399:2,11,16,17,25 406:4 408:10 413:5,15,18,23 415:14,23 416:23 420:18 421:9 443:18 444:1,4,6 451:21 452:2 455:16 464:1 468:21 469:1,3 471:1,15 472:5 474:18 486:16 487:9,17 489:15 489:17,22,24 490:11 492:2,8 494:13 499:12,19 499:25 500:2,7 501:5,8 502:20 503:1,5 505:9,10 506:10,21,24	507:9 510:6 522:17,20,23 523:6,8,13,20,23 524:3,9 525:3,11 526:14 <b>flagged</b> 425:13 435:21,24 437:9 437:18 438:11 452:9 463:25 471:15 483:10,23 484:14 501:7,12 501:14 523:5 526:3 <b>flags</b> 351:22,23 355:12,15 368:6 370:11 391:2 393:9,15,19,21,25 394:1 396:24 397:4,9,11,15,15 397:20,23,25 398:2,3,5,7,8,13 398:16,17 399:11 399:18 400:2,6,13 401:5 402:9 403:3 404:24,25 405:4 405:21 407:21 408:1,6 409:10 411:19 412:23,25 417:20 429:20 430:2,8,11 431:12 432:11 433:24 436:13 444:6 446:8 447:9,12 452:1,17 453:3,14 454:6,16 455:7,16 455:18,19 456:10 459:7 461:5 462:6 465:3 466:4 469:6 469:7,22,23 471:24 472:3 473:14,14 474:12	478:18 482:2 485:7 493:10 494:3 500:15,16 508:19 509:22,24 510:4,5,7 526:12 <b>flip</b> 350:8 352:1 366:14 476:23 <b>floor</b> 345:5 <b>focus</b> 440:22 502:14 <b>focused</b> 368:16 <b>focusing</b> 493:16 <b>folder</b> 362:24 <b>folks</b> 391:16 395:20 396:7,13 <b>follow</b> 466:1 <b>following</b> 368:1 503:13 <b>follows</b> 469:25 472:14 479:1 <b>footnote</b> 478:24 479:1,2 481:8 <b>foregoing</b> 528:13 531:13 532:18 <b>form</b> 357:11 403:18 472:16 487:13 490:24 491:2,3 507:15 523:7,22 524:6,14 <b>formal</b> 391:12 431:9 432:1 <b>format</b> 375:15 428:12 494:19,22 <b>former</b> 448:1 462:7 <b>forms</b> 356:13 367:16 369:3 370:17 <b>formula</b> 451:20 452:6	<b>formulas</b> 453:5 <b>formulate</b> 478:8 <b>formulated</b> 489:15 <b>forth</b> 380:9 <b>forward</b> 530:15 <b>forwards</b> 495:16 <b>foster</b> 393:7 <b>found</b> 379:5 433:14,15 476:19 479:24 482:18 488:18 515:21,25 <b>foundation</b> 381:3 381:10 <b>four</b> 365:6 375:6 422:2 <b>fourth</b> 364:20 375:7 <b>frame</b> 484:24 <b>fraud</b> 353:8 <b>free</b> 531:14 532:20 <b>frequency</b> 428:15 <b>front</b> 348:25 349:4 350:2 353:15 363:16 373:25 390:20 417:24 <b>fulfill</b> 409:21 410:21 411:12 <b>fulfilling</b> 409:6 519:17 <b>fumerton</b> 345:9 347:8 365:20 389:7,12,22 491:10 512:1,14 512:16 513:2,16 513:23 514:19 515:6,20 516:16 517:4 518:1,15,17 518:18,20,24 519:7,8,22,24 521:15,25 522:2,8 523:7,22 524:14
--	--	---	---



524:19 527:7 <b>further</b> 369:6 399:17 401:10 402:13 490:10 492:7 519:25 524:17 527:14 529:1	448:24 449:15 450:14 451:9,17 452:5 453:23 454:2,9,24 455:8 456:2,22 457:11 458:6,14 459:3 460:18,24 462:3 464:7 465:22 466:16 521:5 524:25 525:1,13 525:18,24 526:8 <b>give</b> 356:22 378:5 397:9 412:5 417:9 417:13,21 472:16 473:11 474:6,11 488:17,22 489:22 <b>given</b> 359:20 468:19 473:22,22 490:3 514:20 518:22 520:4 521:7 528:21 <b>giving</b> 356:21 384:5 504:6 <b>glad</b> 359:8 <b>go</b> 349:24 350:1,14 356:1,1 358:1 366:14 371:11 375:14 400:25 412:7 421:6 438:15 459:23 466:19 482:11 491:6,9,11 496:5 512:2 520:12 521:1,13 522:20 526:22 527:9 <b>goes</b> 364:12 388:17 402:17 434:6 456:12 <b>goetz</b> 345:12 <b>going</b> 348:1 349:23 362:25	363:11 371:15 373:18,22 374:16 377:17 380:14 381:8 382:5 385:4 389:1,23 390:4,9 398:15 401:14,17 403:23 407:19,22 407:24 421:13 467:1,6 474:3 477:3 478:7 491:6 491:15 496:7,10 504:16 512:3,6,8 512:16 513:4,4 516:12 518:24 519:4 521:16,19 522:3,13 524:20 524:23 526:18 527:11 <b>good</b> 348:1,21,22 366:17 386:2 421:19 491:18 520:22 <b>gotten</b> 501:12 <b>government</b> 466:13 <b>graduating</b> 428:21 <b>graeme</b> 344:16 <b>grant</b> 345:13 <b>great</b> 349:6 350:5 <b>greater</b> 418:6 <b>grid</b> 494:25 <b>group</b> 391:13,16 395:5 397:22 398:5 403:1,5 <b>groups</b> 391:20 393:9,10 394:2 403:12 <b>guarantees</b> 463:4 463:11 <b>guess</b> 371:10 407:22	<b>guessing</b> 394:16 <b>guidance</b> 368:12 372:8 396:13 399:10 426:15 443:22 449:17,21 450:2 451:18,24 461:3 <b>guide</b> 429:14 511:23 <b>guidelines</b> 460:7 <b>guides</b> 349:15
<b>g</b>		<b>h</b>	
<b>gbush</b> 344:18 <b>general</b> 420:8 421:4 461:7 497:14,25 524:12 <b>generally</b> 444:24 467:25 468:4 497:7,9,11 507:14 524:2 <b>generates</b> 452:20 <b>geographic</b> 422:22 422:25 423:11,12 423:15 <b>getting</b> 406:20 <b>giant</b> 345:2 422:10 422:19 439:6 467:6 486:1 520:9 <b>gisleson</b> 345:17 347:5 421:18,20 422:4,12,20 423:6 423:19 424:1,21 424:23 425:6 427:4,15 428:14 429:24 430:18 432:16 433:19 434:10,15,23 435:7,16 436:15 437:1,7,16,22 438:9,20 439:2,20 440:4,11 441:10 441:20 442:8,16 442:20 443:5 444:17 445:12 446:9,23 447:3,14		<b>h</b> 344:10 <b>hamilton</b> 343:16 528:2,7 529:21 <b>hand</b> 389:8 529:8 <b>handled</b> 453:15 <b>hands</b> 434:7 <b>handy</b> 429:14 <b>happen</b> 451:7,8 <b>happened</b> 403:1 493:22 <b>happening</b> 403:12 522:5 <b>hard</b> 445:15 <b>harm</b> 522:22 523:11 525:6 <b>harmed</b> 525:9,16 525:21 526:4 <b>harmful</b> 522:19 <b>harms</b> 504:25 <b>hart</b> 458:7,17 459:4,14 460:1 461:2,6,15,19,25 462:11 <b>hart's</b> 462:9 <b>hbc</b> 345:2 494:9 494:15 <b>health</b> 435:12 475:4	

[heard - incorporated]

Page 17

<b>heard</b> 368:14 <b>hearing</b> 463:20 <b>held</b> 348:9 379:7 387:20 <b>help</b> 353:12 420:14 423:4 424:22 436:12 442:18 453:3,3 508:17 <b>helped</b> 481:1 490:9,9 492:7 <b>helping</b> 393:1 <b>helps</b> 477:7 <b>hereunto</b> 529:7 <b>hi</b> 467:5 <b>high</b> 504:8 <b>higher</b> 452:23 <b>highway</b> 399:21 <b>hiland</b> 515:8,13 516:1 <b>hildahl</b> 348:10 <b>history</b> 436:11 <b>hit</b> 420:18 <b>hold</b> 381:24 <b>holiday</b> 504:13 <b>holy</b> 486:16 <b>home</b> 517:9,21 <b>hour</b> 389:16,19,23 389:24 487:5,11 487:17,20,25 488:5,10,10 489:5 490:4 496:25 497:7,12,15,17,20 498:2,10,15 499:7 499:10,12 500:1 500:15,21,23,24 501:8,14,18,23 520:2 <b>hours</b> 436:7 519:6 521:7	<b>hpc</b> 486:1 <b>hundred</b> 416:21 <b>hydrocodone</b> 375:25  <b>i</b>  <b>idaho</b> 518:16,19 519:3,9 <b>idea</b> 434:20 493:23 <b>identifiable</b> 438:24 449:11 <b>identification</b> 363:8 373:20 389:4 <b>identified</b> 374:5 397:22 398:8,16 398:18 399:18 400:2 406:4 411:21 412:3,22 413:5,7,22,25 435:21 438:21 446:2 447:12,13 450:8 454:16 456:6 457:9 465:4 469:22 471:24 525:8 <b>identifies</b> 355:6 400:12,13 455:9 455:16 <b>identify</b> 348:13 350:1,24 351:8 352:19 353:8 354:6,17,25 355:2 355:12 357:4,19 358:5,15,17,20,20 359:1,2,23,25 367:1 368:19 369:6,17 370:10 393:15 394:3 409:8 412:6,11 414:15 417:1	429:25 439:1 440:17 443:13 446:12 447:5 451:10,18 453:6 454:11,12,20 455:7 457:5 463:24 464:4 469:20 470:9 471:4 472:1 474:19 508:20 525:7,20 526:2 <b>identifying</b> 353:12 444:2 451:19 <b>ifs</b> 400:6 <b>ignorance</b> 443:23 <b>ii</b> 343:10 <b>il</b> 345:10 <b>illegally</b> 454:4 <b>illegitimate</b> 385:24 416:9,16 417:5,7 418:3,12 420:19 450:20 <b>imagine</b> 359:13 <b>impact</b> 464:5 482:1 <b>impacts</b> 517:14 <b>implement</b> 364:17 366:25 369:21 382:20 386:17 387:12 <b>implementation</b> 367:19 <b>implemented</b> 368:25 409:16,23 410:6,24 411:16 <b>implementing</b> 358:10 <b>implication</b> 381:6 <b>importance</b> 406:1 521:24 522:15	<b>important</b> 372:15 373:6 380:22 393:1 403:14 405:24 459:18 485:6 493:18 503:1,1 504:23 508:20 510:3,3 511:23 512:17 <b>imposed</b> 520:2 <b>imposition</b> 462:17 <b>improper</b> 464:19 <b>improperly</b> 386:10 <b>inadequate</b> 521:8 <b>inappropriate</b> 505:16 513:12 516:4 <b>incidence</b> 477:18 481:1,3 <b>include</b> 369:9 398:3 404:13 406:15 410:14,15 431:12 456:17 468:21 469:8,14 470:14 <b>included</b> 368:21 370:3 398:13 403:21 406:14 407:17 414:1 415:7,22 421:8 427:10 436:2 443:8 463:17 475:7 476:1 507:3 525:20 530:13 <b>includes</b> 429:11 470:18,22 <b>including</b> 372:16 409:7 448:20 <b>incorporated</b> 532:12
---	--	--	---



**[incorporating - investigate]**

Page 18

<b>incorporating</b> 461:9	438:16,18 441:9 451:15 452:2	492:5,21,23,24 493:4,12,14	<b>intended</b> 469:14 470:6,9
<b>incorporation</b> 387:23	464:4 509:11 514:9 516:14	499:15 506:13 508:25 509:4,25	<b>intent</b> 381:17
<b>increase</b> 448:21 452:4	517:15	509:25 511:24 516:15 523:1	<b>intentionally</b> 451:11
<b>increased</b> 477:4 480:9 484:22	<b>individually</b> 506:24 508:14 509:17 510:11,12 510:22	<b>informative</b> 502:23	<b>interact</b> 484:24 <b>interacted</b> 359:13 492:19
<b>independent</b> 379:8 383:10,22,24 384:9,15,24 385:3 385:22 386:11,21 387:24 388:5,7,14 399:14 442:13 449:23 514:17 517:3 518:10	<b>individuals</b> 444:20 <b>indulgence</b> 377:6 <b>industry</b> 441:11 445:7,16 452:7 479:16 511:7,9	<b>initials</b> 438:25 <b>initiated</b> 465:20 <b>input</b> 450:11 453:16	<b>interactions</b> 359:21 403:13 481:14 515:23
<b>index</b> 347:1,13	<b>inference</b> 445:13 445:15	<b>inquiry</b> 396:8 519:5	<b>interested</b> 428:25 476:19 529:4
<b>indiana</b> 343:16 344:14 528:1,8 529:21	<b>influenced</b> 384:2	<b>inserted</b> 492:21,25 494:7,11,15,18 495:13	<b>interesting</b> 489:10 490:12
<b>indicate</b> 380:25 401:9 402:12 420:24 434:3 445:5,9 525:15	<b>information</b> 350:24 358:4 361:20,22,24 362:4,11 373:7 378:5 380:4 383:3 383:18 396:3 409:4 410:1 411:7 412:15 415:10 416:18 419:12 426:15 427:1 429:12 430:23 434:2 436:1,3,24 436:25 437:2,6 438:3,7,24,25 439:16 440:25 442:23 443:2 446:6 448:6 449:12,12 451:25 453:16 456:16,18 463:14,16 472:7 476:11 479:18,19 480:1,16,23 481:12 489:13,19 490:7,18,19,22,25	<b>insisted</b> 382:15 <b>inspection</b> 464:9 464:18 <b>inspections</b> 439:21 439:25 <b>instituting</b> 358:10 <b>instruct</b> 440:13 441:1 447:15 488:16 <b>instructed</b> 459:11 462:1 469:20 474:24 <b>instruction</b> 486:12 488:22 490:3 <b>instructions</b> 461:20 <b>insurance</b> 404:17 406:2,11,23 407:6 407:14,17 503:4,6 507:16 511:11	<b>interfere</b> 383:21 <b>interfered</b> 386:11 463:5,12 <b>interfering</b> 394:18 463:21 <b>interject</b> 511:25 <b>interpretation</b> 354:10 367:19 368:11 406:8 476:3 478:17
<b>indicated</b> 446:16 454:16 468:1,3 476:2		<b>intend</b> 499:11	<b>interpreted</b> 355:18 <b>interpreting</b> 434:7 <b>interrupting</b> 520:22,23 521:2 <b>interruption</b> 371:24 <b>introduce</b> 362:25 363:12 389:1
<b>indicates</b> 416:23			<b>invalid</b> 450:20
<b>indicating</b> 530:13			<b>inventory</b> 506:13
<b>indicative</b> 400:18 401:6 402:9 504:20,22 505:21 506:2			<b>investigate</b> 351:1 351:16 423:14 435:17 442:11 455:24
<b>indirectly</b> 496:1			
<b>individual</b> 356:14 377:8 392:16 395:8 397:4 403:2 411:1 412:7 414:4 414:24 415:2,9 417:4 426:4 427:12 428:10,23			

[investigated - kobrin]

Page 19

<b>investigated</b> 385:12	462:9,11	<b>justified</b> 514:25	<b>knowingly</b> 443:19 443:22 444:3
<b>investigation</b> 422:21 423:20 424:18 426:18 439:14 444:19 445:20 448:11 453:8	<b>january</b> 486:6 <b>jason</b> 344:20 <b>jdgoetz</b> 345:14 <b>jeopardize</b> 451:5,6 <b>jledlie</b> 344:8 <b>job</b> 432:7 <b>john</b> 345:12,17 347:5 421:18,19 525:1	<b>k</b>	<b>knowledge</b> 371:1 433:20 442:11,23 443:15,20 447:4 448:1 461:10 471:25 496:2
<b>investigators</b> 433:13	<b>john.gisleson</b> 345:19	<b>kaitlyn</b> 344:5 <b>keekhoff</b> 344:8 <b>keep</b> 513:6 <b>kept</b> 367:25 <b>kills</b> 456:13 <b>kind</b> 468:8 <b>knew</b> 457:23 490:22 518:2	<b>knowledgeable</b> 461:7 <b>known</b> 435:25 443:25
<b>invoices</b> 492:16	<b>jonathan</b> 346:8	<b>know</b> 354:24 360:11,11 361:23 362:13,15 374:10 374:14 375:16 380:4,8 389:8,13 389:16 397:14 400:12 403:14 407:2 414:22 415:5,16 416:1,3 416:12,13 421:24 422:5,13 426:1 430:9,20 432:10 432:23 433:9 436:10 437:5 447:18 454:3 457:23 458:7,11 460:2,25 461:2,7 461:25 464:12 470:14,17,21 471:1 474:17 479:7 480:13 481:2 490:19 491:1 493:7,9 496:25 497:7,9,11 497:14,23,24 498:1,6,10,15 506:20 515:11,13 516:8 520:6	<b>knows</b> 432:18 <b>kobrin</b> 345:4,7 347:6,11 466:19 467:4,5 468:7 469:5,13,19 470:16 471:20 472:4,11,19,24 473:8,16,20,24 474:2,9,15,22 475:2,10,16 476:21 477:23 479:11 480:5,6,12 482:3,7,16,22 483:4,17 485:11 485:16 486:4,15 486:22 487:3 488:4,8,21 489:1 489:14,21 490:14 490:21 491:5,11 491:17 492:12 494:21 495:6 496:5,12,21 497:6 498:14,22 499:20 500:14,20 501:10 501:17 502:4 503:8,15 504:7 506:19 507:20 508:9 509:7,13 510:9 511:3 512:8 512:13,19,22
<b>involve</b> 457:24	<b>jones</b> 345:8,12	<b>knowing</b> 428:25 439:10 443:24 451:12	
<b>involved</b> 380:16 383:4 409:9 458:11	<b>jonesday.com</b> 345:11,14		
<b>involvement</b> 475:8	<b>josh</b> 466:17 467:5 513:3 520:21 526:9		
<b>involving</b> 368:1 459:8	<b>joshua</b> 345:4 347:6,11 467:4 526:11		
<b>issue</b> 394:21,24 401:9 402:13 430:5 442:9 460:5 460:7 500:1 516:9 520:18	<b>judge</b> 509:14 520:15		
<b>issued</b> 428:5,8 429:25 430:13,21 434:25 443:23 450:17 451:11,18 518:7	<b>judging</b> 505:17 <b>judgment</b> 379:8 379:16 381:24,25 383:10,22,25 384:9,16,24 385:3 385:23 386:12,21 388:6,7,14 399:15 449:3,23,23 456:24 491:8 513:18 514:7,17 517:3,15 518:11		
<b>issues</b> 372:18 450:9 456:9 460:3 460:10 464:10 516:13 521:12	<b>judgments</b> 387:25 <b>june</b> 343:17 348:3 390:9 467:1 528:15 529:9 530:4		
<b>issuing</b> 447:5			
<b>iteration</b> 375:2,9			
<b>j</b>			
<b>jacton</b> 344:22 <b>jaffe</b> 346:8 <b>james</b> 344:4 <b>janet</b> 458:7,17 459:4,14,25 461:2 461:6,15,19,25			

[kobrin - lpa]

Page 20

520:8,19 526:11 526:18,23 527:2 <b>kraig</b> 348:10	381:22 427:9,16 427:17,19 429:12 431:2	<b>level</b> 351:22 357:24 367:14 369:18 417:1 507:7 515:25	<b>llp</b> 344:9,15 345:3 345:16,21
<b>l</b>	<b>lawsuit</b> 453:12		<b>local</b> 424:11 455:22
<b>lacked</b> 443:16 451:12 461:22 <b>lacking</b> 418:17 <b>lake</b> 420:11 421:21,25 422:6 423:1,10,16,22 424:3,8 425:2,9,21 434:17 439:22 442:24 443:13 444:12,18,25 445:19,23 446:14 448:3,7,15,20 450:5,16 451:10 453:24 454:4 462:21,24 464:9 464:12 466:7 526:2 <b>lakeside</b> 344:10 <b>language</b> 403:20 <b>large</b> 375:23 439:4 528:8 <b>larger</b> 422:18 423:10 507:1 <b>late</b> 382:9 <b>latitude</b> 518:22 <b>launched</b> 349:18 <b>laura</b> 346:2 <b>law</b> 352:5,10,12 357:17,20,20,22 369:1,2 427:2,5,8 427:13,19,25 428:5,7,16,18 429:1,4,13,15,17 429:19,23 432:20 466:10,13 522:11 <b>laws</b> 370:15 372:18 381:17,22	<b>lawyer</b> 521:9 <b>lawyers</b> 437:10 453:15 <b>lay</b> 381:3,10 <b>ldunning</b> 346:5 <b>lead</b> 373:3 <b>leading</b> 376:22 497:19 <b>learned</b> 443:2 <b>leave</b> 376:23 <b>led</b> 435:12 489:22 <b>ledlie</b> 344:4 <b>left</b> 447:23 491:19 493:19 <b>legal</b> 348:10 492:14,19 493:21 493:25 519:17 530:1 533:1 <b>legitimacy</b> 376:16 <b>legitimate</b> 370:22 375:25 385:2 406:5 434:25 441:25 443:16,20 446:5,19,21 447:6 450:18,23,25 451:12 453:11 461:22 505:4,5,6 505:12 506:7,18 506:21,22 508:3,7 510:15 511:15,18 511:20 523:10 525:5 <b>letter</b> 372:24 381:21 530:19 <b>letters</b> 372:24 447:11,16	<b>levels</b> 464:11 <b>levin</b> 346:2 <b>levinlaw.com</b> 346:5,5 <b>lewis</b> 345:16 <b>liber</b> 344:9 <b>license</b> 427:21 432:5 451:5 <b>licensed</b> 351:6,10 351:14 431:8,25 432:10 <b>licensees</b> 447:25 <b>licensure</b> 432:8 433:23 <b>life</b> 451:6 <b>limit</b> 520:2 <b>limited</b> 409:7 455:6 <b>limiting</b> 359:5 <b>limits</b> 463:3,11 <b>line</b> 519:5 530:13 532:7 533:3 <b>lines</b> 396:18 404:3 <b>list</b> 384:20 438:11 502:6,15 <b>listed</b> 391:20,25 463:24 501:13 510:17 532:7,17 <b>listing</b> 532:7 <b>litigation</b> 343:5 348:6 404:22 530:6 531:3 532:3 <b>little</b> 365:20 442:16 <b>live</b> 427:14 <b>llc</b> 344:3,14,14,14	<b>llp</b> 344:9,15 345:3 345:16,21 <b>local</b> 424:11 455:22 <b>lodge</b> 380:14 520:1,9 <b>logical</b> 451:7 <b>long</b> 382:11 404:14,23 441:12 441:15,22 459:16 471:9 514:25 <b>longer</b> 442:6 <b>look</b> 364:19 365:18 371:12 374:4,21 382:4 400:11 412:8 413:15 414:3 415:2,13 416:11 438:16 439:25 453:13 454:6,7 463:19 464:14,22 464:23 478:4,5 484:11 489:25 509:12 510:10,11 511:23 521:1 <b>looked</b> 353:24 361:14 384:19 386:2 422:8 439:1 465:6 489:9 509:17 <b>looking</b> 374:8 461:9 467:7 481:5 502:12 505:13 506:4 508:10,13 508:14 514:8 <b>looks</b> 452:16 508:2 <b>lost</b> 401:12 512:1,1 <b>lot</b> 359:14 412:23 <b>lower</b> 500:9 <b>lpa</b> 346:10

[m - michael]

Page 21

<b>m</b>	<b>may's</b> 375:20	<b>measures</b> 477:4,15	463:5,12 465:11
<b>m</b> 344:20	<b>mccann</b> 412:25	477:16 480:9	478:11 487:23
<b>machines</b> 366:8	413:7,25 469:11	<b>measuring</b> 481:2	490:1 498:20
<b>madam</b> 530:10	469:20 471:21,25	481:18	522:20
<b>main</b> 500:21	473:3,11,13,18,18	<b>mechanics</b> 360:11	<b>medicine</b> 394:18
503:19,24 504:13	474:6 485:21	<b>media</b> 348:3	396:22 449:9
<b>maintain</b> 350:18	487:24 488:16,20	349:14 390:7	<b>meet</b> 358:22
353:1 429:10	489:4,11,15	466:24	367:25 396:14
436:17,24	490:22 491:25	<b>medical</b> 370:22	434:4
<b>maintained</b>	492:4,18,21,25	376:1 385:2,12	<b>meeting</b> 394:12,23
437:24	493:6,13,14,24	420:19 425:12	480:21
<b>making</b> 379:7	494:6 495:3,7,12	435:1 441:25	<b>meetings</b> 460:4
407:7 410:16	495:14,17,20,24	443:16,21 446:5	<b>meets</b> 480:18
516:20 517:21	<b>mccann's</b> 470:15	447:6 448:11	<b>melsner</b> 344:7
<b>manage</b> 447:24	489:8 495:23	449:14 450:18,23	<b>member</b> 390:14
<b>management</b>	496:2 501:22	450:25 451:13	458:21 461:12
361:4 446:22	<b>md</b> 343:3 344:17	453:11 455:21	<b>members</b> 463:18
<b>mandate</b> 383:14	348:8	461:22 468:22	<b>memory</b> 360:4
465:5	<b>mdl</b> 343:3	469:9,15 470:7,18	<b>mentioned</b> 375:21
<b>mandated</b> 465:17	<b>mean</b> 355:19	478:23 479:19	514:12
466:3,5	359:12 363:2	505:12 523:10	<b>merit</b> 343:14
<b>mandating</b> 387:3	389:14 398:2	525:5	528:5
478:23	402:22 423:4	<b>medically</b> 477:7	<b>met</b> 391:9 404:2
<b>mandatory</b> 465:2	424:22 434:7	<b>medication</b> 358:18	501:25
465:9	500:12	359:4 360:2	<b>methodologies</b>
<b>march</b> 390:13	<b>meaning</b> 393:23	370:21 385:1	453:5
<b>marcus</b> 345:3,6,7	<b>means</b> 351:20	400:17 443:15	<b>methodology</b>
<b>mark</b> 363:6	407:2 420:8	445:1 446:1,10	451:20 452:6
<b>marked</b> 362:24	450:19 495:19	449:4 450:17	<b>methods</b> 350:18
363:8 373:15,20	502:19	522:18,19	<b>metric</b> 464:13
389:4 390:12	<b>meant</b> 383:25	<b>medications</b>	467:16 468:3,20
<b>market</b> 345:17	420:7 512:13	372:16 385:1	472:5 475:20,21
497:20	513:17	395:15 396:16	477:20 478:9
<b>master</b> 346:10	<b>measure</b> 467:19	419:19 435:13	485:18,24 486:7
390:1 491:8	475:12 477:24	438:1 442:5	488:5 526:14
520:20 526:17,19	479:16 482:8	444:21 445:19,22	<b>metrics</b> 384:3
526:20,25	483:8,21,23 485:3	446:22 448:13	459:18 462:18
<b>match</b> 398:17	485:12	449:20 451:22	463:21 478:11
<b>matter</b> 348:5	<b>measured</b> 482:5	453:10 454:3	<b>michael</b> 344:3
455:20 458:13	487:5	455:5,23 456:12	347:9 462:7
528:12		458:25 461:21	521:22 522:11

[michael - notary]

Page 22

530:5 <b>middle</b> 350:13 374:13 <b>midway</b> 350:17 <b>midwest</b> 530:17 533:1 <b>mike</b> 380:19 381:5 473:20 521:25 522:2 <b>miles</b> 399:3,6,7,12 399:15,16 413:19 526:14 <b>miller</b> 346:7 <b>mimics</b> 357:20 <b>minds</b> 398:21 399:6,24 400:5 <b>minute</b> 459:13 497:1,7,12,17,20 498:2,15 499:7,10 518:22 521:11 <b>minutes</b> 389:17 459:24 497:15 521:14 <b>mischaracterizes</b> 415:19 <b>misconduct</b> 518:8 <b>misrepresent</b> 377:25 <b>misrepresented</b> 378:5 <b>missing</b> 374:13 415:20,25 <b>misspoke</b> 493:19 <b>misstates</b> 524:6 <b>mistake</b> 492:10 <b>misuse</b> 477:9 <b>mix</b> 456:18 <b>mmes</b> 452:19 <b>model</b> 347:15,15 362:20,20 363:13 363:14,20 364:5	364:11,15,21 365:6 367:13,17 367:18 368:22,24 369:1,6 370:1,4 371:20 441:2 449:21 <b>moment</b> 496:6 512:2 <b>month</b> 486:5,9,14 <b>morgan</b> 345:16 <b>morganlewis.com</b> 345:19 <b>morning</b> 348:1,21 348:22,23 405:25 421:19 513:7 <b>mortar</b> 510:18 <b>motley</b> 344:3 522:12 <b>motleyrice.com</b> 344:7,7,8,8 <b>mount</b> 343:16 344:6 528:14 <b>move</b> 371:15 378:7 411:8 480:5 <b>mr</b> 396:3 <b>n</b> <b>n</b> 344:1 <b>nabp</b> 359:12 362:18,18 363:21 364:2 368:11 370:25 371:5,11 372:23 373:1 380:9 386:9,16 387:11,16,18,22 391:6 393:18 396:17 427:1 428:4,16,18 432:7 432:17,19,24 433:3 440:13,13 441:1 447:15,21 448:2 449:16	451:18 461:3,9,12 461:17 463:14,18 463:19 465:8,14 466:1,13 480:17 <b>nabp's</b> 373:13 461:8 466:10 <b>nacds</b> 502:14,25 504:13 <b>name</b> 348:10 381:7 404:8 405:17 421:19 426:4 467:5 487:24,25 488:5,6 488:10,13 509:2,3 530:6 531:3,4,15 532:3,4,21 <b>named</b> 487:17 <b>names</b> 460:25 <b>napb</b> 452:15 <b>narxcheck</b> 452:15 452:16,16 453:2,7 <b>national</b> 343:4 347:16 348:5 363:14 374:6 435:10 530:6 531:3 532:3 <b>nationwide</b> 453:22 517:10 <b>near</b> 487:4 <b>nearly</b> 502:17 <b>necessarily</b> 410:15 <b>necessary</b> 393:18 409:5 461:4 <b>need</b> 350:1 371:20 376:1 378:17 379:3 410:1 491:6 510:10,11,22 523:13 <b>needed</b> 374:23 388:24 396:20 403:24 409:17	427:3 434:4 441:5 464:25 <b>needs</b> 390:1 506:11 523:6,8 525:3 <b>negate</b> 443:24 <b>never</b> 461:17,17 492:19 493:24 496:1 <b>new</b> 382:5 389:1 520:4 <b>news</b> 374:6 <b>newsletter</b> 347:17 374:1,9,10 375:16 375:20 379:23 380:3,5 382:2 429:10,11,25 <b>newsletters</b> 372:8 373:6 430:6,9,12 430:21 <b>nice</b> 429:13 <b>night</b> 377:23 <b>nine</b> 363:4 <b>noncontrolled</b> 425:1 <b>nonlegitimate</b> 383:5 444:16 450:9 451:5 <b>nonresponsive</b> 411:9 <b>normally</b> 404:18 406:24 <b>northern</b> 343:1 348:7 <b>northwest</b> 344:20 <b>notarial</b> 529:8 <b>notarized</b> 530:14 <b>notary</b> 343:15 528:6 529:16 530:25 531:10,18 532:15,23 533:23
---	---	---	---



[note - oh]

Page 23

<b>note</b> 379:6 530:12 <b>noted</b> 380:21 484:20 492:16 520:21 <b>notes</b> 349:7,12,15 415:8,22 420:5 437:13 471:14 528:18 <b>notify</b> 369:18 448:3 <b>number</b> 348:3,8 353:12 367:23 382:12 383:16 390:7 400:12 413:5,16 417:10 418:15,16,21 419:1,2 420:4,22 420:23 422:10 439:4 444:11,13 444:15 445:18 452:8,9 466:24 469:7 471:15 478:4 481:6 483:9 483:22 486:16 495:10 500:9 503:9 504:8 507:6 507:12 508:11,22 508:23 510:15 530:7,13 <b>numbers</b> 421:8 445:7 469:17,23 472:21 473:9 489:9 494:23,24 495:2,8,12,13 532:7 <b>numerous</b> 440:21	<b>oath</b> 525:25 <b>object</b> 374:16 381:9 523:7 524:6 <b>objected</b> 403:20 405:16 <b>objection</b> 352:14 353:14 354:7,21 355:5 356:10 357:8 358:8,19 359:7 360:3,23 361:16,21 362:7 364:6 367:5 368:23 369:23 370:5,5 371:4 375:4,11 376:25 377:5,12 379:18 380:2,15,21 382:22 384:12 386:1,13,19 387:17 388:8,16 391:11 392:9,15 393:3,22 395:25 396:10 397:3,17 397:24 398:24 399:8 400:1,8 402:25 405:7 406:13 407:1,8 408:8 409:24 410:9,25 411:10 411:17,25 412:4 414:11,17,23 415:6,18,18 416:4 416:17 417:8 418:4,25 419:7,23 420:20 421:3,10 422:1,7,16 423:3 423:17,24 424:20 425:4 426:25 427:7 428:9 429:21 430:16 432:13 433:11,25	434:13,19 435:5 435:14 436:5,19 437:4,11,20 438:5 438:14,23 439:9 440:2,8,18 441:18 442:2,15 443:3 444:9 445:3,25 446:15,25 447:7 448:23 449:10 450:7 451:1,14,23 453:21,25 454:5 454:15,21 455:1 455:14 456:20 457:7 458:1,10 459:2 460:9,22 461:23 464:3 465:13 466:12 468:5,24 469:10 469:16 470:8 471:17,23 472:8 472:17,22 473:6 473:12,19 474:8 474:13,20 475:1,6 475:14 476:20 477:22 479:9 480:11 481:23 482:6,10,19,25 483:16 485:9,14 486:2,10,19 487:1 488:1,7,19,24 489:7,16 490:6,17 491:4 492:9 494:17 495:4 496:19 497:3 498:13,17 499:16 500:11,19 501:9 501:16 502:2,24 503:12 504:4 506:3 507:17,25 509:6,9,18 510:24 511:21 513:14,21	514:10 515:4,16 516:7,23 517:24 518:12 519:20 520:2,9 521:5 523:16,22 524:14 525:12,22 526:5 526:16 <b>objections</b> 380:20 520:20 <b>objective</b> 384:1 396:18 <b>obligation</b> 354:16 355:1,4,11 397:2 519:18 <b>obligations</b> 397:2 519:17 <b>observed</b> 520:21 <b>obtain</b> 430:15 <b>obtained</b> 444:20 445:1 <b>obtaining</b> 468:12 <b>occur</b> 451:2 452:24 522:22,22 <b>occurred</b> 416:25 416:25 464:19 480:21 493:9 498:9 <b>occurring</b> 384:17 455:20 460:14 508:21 <b>occurs</b> 367:14 <b>offensive</b> 403:10 <b>office</b> 404:14 517:9,21 <b>officer</b> 426:7,11 <b>official</b> 531:15 532:21 <b>oftentimes</b> 401:7 402:10 <b>oh</b> 344:11 402:4 418:10 479:4
<b>o</b>			
<b>oarrs</b> 447:5,8,12 447:22 457:6,10 464:25 465:1,10 479:22			

[oh - oxycodone]

Page 24

512:15 <b>ohio</b> 343:1 344:14 346:11 347:18 348:8 351:7,11,15 352:5,10,12 358:2 372:12 374:1,15 375:22 376:4,9,19 377:21,23 379:12 380:4,8,13 381:20 381:22 425:15,18 425:19,20 426:2 426:11,14,15,16 426:24 427:12 429:1,4,8,9,10,11 429:12,16,18 430:1,5,9,10,13,14 430:20,22,24 432:21,21 433:4,7 433:8,17,20,22 434:1,4,8 438:12 439:3,12,14,19,21 440:5,7,14,14 441:1,15 447:4,9 447:15,18,21,23 447:25 448:2,20 449:9,17 452:14 453:22 457:25 464:8,15,17 465:6 465:8,10,15 466:1 466:6,8,9,9,13 475:19 476:8,13 476:14 478:14,21 479:5,19,21,23,25 524:11 530:2 <b>okay</b> 348:17 349:14,17,23 350:3 353:24 354:3,24 355:22 355:23 357:14 363:12 364:11 365:3,25 366:4,20	367:8 368:14 371:15 373:21,25 374:19 375:20 378:7,18 379:6 380:20 385:21 389:1 390:3 391:15 393:6 396:7 397:11 401:22,24 402:4 403:20 404:5 405:16 406:19 408:3,20,23 410:4 411:8 413:8,15,16 415:25 417:4 419:4 420:2 431:18 456:15 457:23 475:3 478:19 479:4 482:23 483:15 491:20 514:4 515:7 521:15 522:8 524:1 <b>once</b> 406:1 449:23 450:16 455:9,15 480:20 521:3 <b>oncologists</b> 414:21 <b>ones</b> 350:1 <b>online</b> 363:1 512:18 <b>open</b> 350:5 362:24 363:9 373:15 389:3 396:18 404:3 <b>operates</b> 480:17 <b>operations</b> 369:7 376:12 426:2 458:12 <b>opiate</b> 343:5 348:6 420:12 530:6 531:3 532:3	<b>opiates</b> 420:12 <b>opined</b> 352:20 <b>opinion</b> 351:6,10 351:14 352:6 353:11 354:12 355:20 356:19 357:17,25 358:1,9 358:24 382:25 383:13 409:2,13 409:20 410:8,14 410:18,20 411:12 414:5 418:10,10 419:10 455:15 476:2 485:18,24 486:5 507:5,21 508:1 510:2,6,21 515:15,17,19 523:1,4 524:10 <b>opinions</b> 353:11 357:16 371:16 372:1 408:24 <b>opioid</b> 424:14 435:13 438:1 443:15 444:13 445:1,19,22 447:19 448:13 449:4,20 450:17 450:20 451:11,21 453:10,18 454:3 458:25 461:21 463:4,12 465:11 469:25 483:8,18 483:21 484:6,21 487:10,12 499:15 504:19 505:20,25 507:8 509:15 522:16 523:5 524:3,9 525:15 <b>opioids</b> 372:16 412:17 416:19 417:11,23 419:14	420:22 444:11 446:20 448:22 508:23 <b>opportunity</b> 403:24 <b>oral</b> 343:13 <b>orally</b> 459:5 <b>order</b> 388:1 505:12 507:23 510:13 520:14 <b>organization</b> 394:11 <b>organizations</b> 390:15 <b>original</b> 489:10 <b>originally</b> 375:5 <b>osco</b> 371:8 496:16 <b>ought</b> 390:2 <b>outside</b> 358:2 412:17 419:14,21 420:4 453:12 456:12 463:7 497:22 522:21 <b>overall</b> 416:24 432:14 506:8 525:14 <b>overdosed</b> 444:20 444:25 <b>overdoses</b> 417:12 420:24 444:13,18 525:15 <b>overlapping</b> 467:20 470:1 471:8 <b>oversees</b> 426:6 <b>oversight</b> 350:10 352:2 <b>ownership</b> 402:24 <b>oxford</b> 345:5 <b>oxycodone</b> 375:24
---	---	---	--

[p - pays]

Page 25

<b>p</b>	<b>pain</b> 375:22	514:8,22,23	<b>patients</b> 351:2,16
<b>p</b> 344:1,1	446:11,22 458:25	516:20,21 517:11	361:7 376:11,22
<b>p.m.</b> 496:8,11	461:21	<b>particularly</b>	395:1 403:4
512:4,7 521:17,20	<b>panel</b> 391:9,15	375:24 412:17	404:12 420:11
524:21,24 527:12	400:13	419:14 430:8	423:21 424:3,7
<b>pa</b> 345:5,13,18	<b>papantonio</b> 346:2	433:13	434:11,18,22
<b>pad</b> 349:12	<b>paper</b> 349:7,12	<b>parties</b> 521:7	435:20,23,24
<b>page</b> 346:3 347:2	<b>paragraph</b> 350:13	528:23,24	455:3,4 467:24
347:14 350:6,8,8	350:15,22 355:10	<b>partnered</b> 470:18	468:3 487:11,20
350:13 352:1	401:4 407:24	<b>parts</b> 427:19	489:25 500:10,24
353:24 363:18	408:9,15 477:1,2	<b>party</b> 396:18	501:3,5 502:18
364:20 365:24	<b>parameter</b> 399:12	403:23 405:13	503:17,21 504:9
366:15,18,20	399:13	529:3,6	506:10 525:16
367:23 374:4,14	<b>part</b> 353:3,16	<b>pass</b> 421:14 512:8	526:15
374:21,25 375:6,7	354:22 360:13	512:13 524:15	<b>pattern</b> 362:5
376:7,8 378:24	361:7,11 368:8	527:5	385:13 454:25
381:7 382:4,6,8	369:4 380:12,12	<b>passed</b> 394:13	455:5,10,16 456:6
391:21 392:1	395:17 396:1	395:13 463:18	456:17 489:24
397:7,21 398:8,17	406:15 408:15	<b>patient</b> 370:21	508:20
400:11,25 401:24	422:21 423:20	399:2 406:3 407:6	<b>patterns</b> 350:24
402:2 408:21,23	424:17 425:22	407:14 410:1	351:8 352:19
413:11,15 419:9	426:12 428:3	413:19 415:8	354:6,17 355:2
431:14,17 457:15	433:23 435:17	420:5 424:10	357:4,19 358:5,17
457:16,20 468:12	439:24 440:12	425:12 435:4,13	359:3,25 361:15
469:7 476:23	441:21 445:21	436:2,4,6,10,10,11	366:12 367:2
478:25 479:3	459:8,20 467:23	436:17,18,21,22	368:19 369:17
482:20 483:2,10	472:18 494:19	437:2,8,13,17,24	370:10 409:8
483:13,25 484:1,6	501:19 532:9	438:3 440:24,25	410:17 440:17
484:11,11,20	<b>partially</b> 415:7	452:17,18,20	454:12,12,20
485:8 486:17	<b>participants</b> 403:6	455:11,13,23	455:2,7 457:5,9
487:4 489:25	<b>participated</b> 392:2	456:1,7,11 457:1	<b>pause</b> 521:11
502:5,6 520:5	<b>participation</b>	468:10,14 469:25	<b>pay</b> 404:15 406:21
530:13,15 532:7	477:4 478:23	470:22,24 471:14	<b>paying</b> 404:23
533:3	480:8	478:7,10 484:7	503:7 506:10
<b>pages</b> 365:6 375:6	<b>particular</b> 367:23	503:3 504:25	<b>payment</b> 505:4
380:24	394:21 424:19	506:17 522:22	<b>payments</b> 502:7
<b>paid</b> 502:18,19	425:2,9 435:12	523:11 525:6,7,20	505:1,15 507:7,9
503:17,22 504:2	449:19 455:11,11	526:2	507:23
504:19 505:20	457:1 464:24	<b>patient's</b> 438:7	<b>payor</b> 405:13
506:1 507:13	499:18,25 507:24	451:6	<b>pays</b> 503:3
509:16 510:20	509:15 510:18		



<p><b>pdmp</b> 457:10 465:15,18 477:3,6 477:19,21 478:3,4 478:9,22,23 480:8 480:16,18,19,23 481:13,14 482:1 <b>pdmp's</b> 465:19 <b>pdmps</b> 465:24 484:19 <b>pdx</b> 496:22 <b>pen</b> 349:13 <b>pennsylvania</b> 458:18,23 461:9 461:14 <b>pensacola</b> 346:4 <b>people</b> 375:25 395:10 406:19 416:21 456:13 480:22 481:2 <b>percent</b> 417:16,17 417:17 418:6,8,11 418:16,22,24 419:4,19 420:9 421:2 445:8 502:17,23 503:9 503:16,21 504:8 504:18 505:20,25 506:9,9,16 507:14 508:4,4,4,5 509:14 510:5,6 511:10,16 511:17 524:2,13 <b>percentage</b> 417:6 417:21 418:1 420:17 424:25 504:23 505:14 506:13 507:22,22 508:3 510:3,19 511:13,22 524:9 <b>percentages</b> 506:4 507:2,3 509:21 510:14</p>	<p><b>perfectly</b> 511:19 <b>perform</b> 432:18 433:9 460:12 525:23 <b>performed</b> 446:24 <b>performing</b> 489:9 <b>period</b> 484:19 486:6 518:21 <b>periodically</b> 372:14 <b>permitted</b> 514:12 <b>permitting</b> 513:25 <b>person</b> 373:3 406:2 420:12 444:25 445:4,9 461:7,11 529:2 <b>personally</b> 385:9 438:24 461:18 531:11 532:15 <b>personnel</b> 351:1 <b>perspective</b> 503:2 <b>peter</b> 344:10 <b>pharmacies</b> 350:14,17,23 351:20 359:13,21 361:5 366:9 371:3 371:12 376:14 380:10 382:25 383:1 387:12 394:5 403:7 407:12 410:6 411:15,21 412:2,7 412:10 419:20 421:9 422:11 430:14 433:15 434:17 435:10 436:16,23 437:19 439:22 441:23 442:10,12,14,24 443:2 444:22 445:2 447:17</p>	<p>448:3 452:18 453:8,18,19 462:21 463:7,9,9 464:14,15 466:7 466:15 475:19 505:14 510:17 511:15 516:3 517:20 519:14 525:10 <b>pharmacist</b> 353:9 354:16 355:8,16 355:19 359:17 360:8 361:9,15 362:5 366:12 368:5,9,10 369:18 370:14,19 371:8 379:6,14,15,24 381:24,25 383:5 383:18 384:1,16 385:2,7 386:4 387:1,7,19,24 388:1,5,13,22,24 398:4,23 399:13 402:20 407:20 408:12 410:17 411:1,6,6 415:15 415:22 416:2 425:9 428:22,25 429:1,3,7,19 430:1 430:7 432:18,23 434:16 435:2,3,9 435:11 436:7,12 437:23 438:18,22 439:1 440:21 441:12,16,22 443:13,17,25 444:3 449:22 450:1,11 452:25 455:12,15,24 456:4,9,15,19 459:19 463:25</p>	<p>464:1 465:12 503:2 505:10 506:15 508:2,6 514:6,21 516:19 517:22 519:17 523:9 525:4,9 <b>pharmacist's</b> 383:22 384:8,24 386:11 388:6 396:4 397:1 455:17 456:3,23 509:2 517:2,6,14 <b>pharmacists</b> 350:25 351:2,12 351:17,22 353:10 357:21,24 358:4 358:18 359:4 360:1,13 361:10 361:19,20,25 362:11 371:17 372:9,15 376:9,21 379:22 380:6,6,7 381:15,17,21 382:16 383:9,14 384:18 385:22 386:20 387:3,14 388:11 393:1,12 393:25 394:5,6,10 394:14,15,17,25 395:14,18 396:2,8 396:20,21 397:16 397:21 400:22 401:1 402:1,6 403:5,7 404:11 407:2,25 408:4 409:4,5,13,17,20 409:25 410:12,21 411:12 425:15,18 425:19 426:20,24 429:9,14 430:14 430:22 431:4,8,21</p>
--	---	--	--

431:25 432:8,9 433:9,22 434:2,11 434:21 435:19,25 436:8 438:10 439:5,13,18 441:8 442:12,23 443:7 450:5 459:6,17 460:11,14,19 461:20,25 462:2,5 463:15,16,22 464:24 465:10 466:14 471:13 480:24,24 498:12 507:4 511:9 513:10,17,25 514:13,15,16 517:10,23 518:10 519:15,16 520:3 523:2 <b>pharmacy</b> 344:13 347:15,16,18 351:1,6,10,14 352:18 353:1 354:5 355:1,6,9,17 355:19 357:3,18 358:1,2,5,9,15 359:1,6,9,16,22,24 360:5,6 361:18 363:14,15 364:12 364:21 365:7,11 366:4,10,16,21,24 366:25 367:13,20 367:25 368:2,17 368:19 369:16 370:8 371:5,6 372:7,20 373:4,8 374:2 376:20 377:4,22 379:22 380:5,8,13 381:20 383:13 385:9,11 385:22 386:16	387:3,19,22 388:11 397:23 403:5,12,12 404:15 409:16 411:22 412:9 421:24 422:6,14 423:1,9,15,22 424:2,7,19 425:2 425:16,21 426:2 426:12,14,16,16 426:20 427:2,5,8 427:10,13,22,25 428:5,7,16,19,20 428:22 429:4,13 429:17,19,23 430:5,7,13,22,24 432:22 433:4,7,8 433:18,20 434:1,4 435:19 436:9,18 437:25 438:12 439:4,11,12,15,19 439:21 440:6,7,14 440:15,20 441:1 441:11 445:10 447:4,9,16,19,22 448:2,4 449:18,18 451:19 452:7,25 454:11 455:9 456:6,16 458:18 459:12 460:3 461:4,15,16 462:17,24 463:2 463:20 464:8,9,18 464:22,23,24 465:4,6,9 466:9,15 471:24 475:4,12 476:13 486:24,24 496:13,18 497:13 497:14,19,24 498:4,6 499:8 503:2,10,19,24	504:10 505:13,17 505:22 506:8,14 506:25 507:6,10 507:24 510:19 511:10,13 516:5 516:13,15 518:3,6 519:10 520:3 523:3 524:12,12 <b>pharmacy's</b> 354:16 379:13 413:1 439:25 440:15 476:8,14 506:12 <b>phi</b> 509:1 <b>philadelphia</b> 345:18 <b>phone</b> 490:15 492:20 495:22 530:3 <b>physician</b> 383:3 385:7 387:9 404:14 451:3 452:14 467:25 468:4 469:1 470:22,25 503:21 516:11 <b>physician's</b> 470:23 502:18 503:17 504:9 <b>physicians</b> 391:23 394:4,9 395:17,21 396:3,19 400:21 <b>pick</b> 484:17 <b>picked</b> 486:5 <b>pill</b> 366:7 <b>pills</b> 453:18 498:12,24 499:5 <b>pittsburgh</b> 345:5 345:13 <b>pivot</b> 382:5	<b>place</b> 376:13 381:23 <b>plaintiff's</b> 437:10 <b>plaintiffs</b> 344:2 522:12 <b>pleasant</b> 343:16 344:6 528:14 <b>please</b> 348:13 349:20 350:5 362:24 378:16,25 379:6 381:8 389:12 413:11 431:16,19 492:13 521:23 530:11,11 <b>pocket</b> 503:7 <b>podgurski</b> 462:7 <b>poerschke</b> 346:3 <b>point</b> 352:24 355:9 359:6,8 361:10 367:2,9 405:24 408:6,9 429:17 444:14 449:16 461:14 482:12 497:16,21 498:1 498:18 502:23 520:1 527:10 <b>pointed</b> 399:10 <b>points</b> 362:8 394:2 444:10 458:22 489:19 502:9 <b>policies</b> 383:2,20 384:17 386:10 387:13 442:10,13 443:8,11 502:7,16 513:8,24 515:2 518:9 <b>policy</b> 383:9 384:22 388:4 430:25 516:25 517:7,8,14
--	---	--	---

<b>polster</b> 520:15	479:23 516:12	509:3	433:10 434:24
<b>populations</b> 424:15	524:12	<b>prescribers</b> 351:2	435:13,21 436:12
<b>portion</b> 374:12,13	<b>practiced</b> 425:18	351:16 377:22	438:1,11,22
<b>portions</b> 372:23	<b>practices</b> 364:16	384:19,21 386:18	440:23 441:9,13
<b>posed</b> 399:9	424:18,21 425:8	387:15 393:12,24	441:17,24 442:4
<b>position</b> 356:15	425:21 448:8	395:1 397:15	443:14,16,18,19
359:14 380:12	458:24 459:9	402:2 403:2,13,14	444:4,11,13,21
462:8 516:4	<b>practicing</b> 371:6	433:16 438:18	445:1,10 448:22
<b>positions</b> 403:20	376:21 380:6	447:5,10,11,13,18	450:18 452:1
<b>possibility</b> 452:3	<b>practitioner</b> 355:7	447:20 448:4	455:13 456:5,25
<b>possible</b> 349:19	355:18 476:14	449:2,6,8 450:3,12	460:8 463:5,24
369:19 393:2,15	<b>practitioners</b>	452:19 465:17	465:11 468:10
393:19 410:17	409:9 449:14	467:16,21 468:14	484:18 487:10
477:9	478:8 479:15	468:22 470:2,10	497:15 503:4
<b>possibly</b> 409:9	<b>pratt</b> 344:16	472:6,10 478:5,5	504:22,24,25
<b>potential</b> 362:5	<b>preexisting</b> 435:3	478:10 480:24,25	505:5,5 506:18,21
366:12 401:9	<b>prepared</b> 520:11	481:6 490:2 515:3	506:23 508:3,8,24
402:12 452:2,23	<b>preparing</b> 425:25	<b>prescribing</b> 383:4	508:25 509:12,16
454:16 456:6,17	<b>prescribe</b> 449:4	390:18 395:14	510:7,12 513:11
484:24	471:3	425:7 448:8,13,22	513:19 514:1,5,9
<b>potentially</b> 400:18	<b>prescribed</b> 395:16	455:6 470:22,23	514:22 517:23
<b>power</b> 401:13	470:1	477:5,8 478:15	519:16 522:17,24
<b>powerpoints</b>	<b>prescriber</b> 377:25	487:6,18,25 488:6	523:5,9,23 525:5
434:5	382:11,12 383:19	488:9,10,11	525:14 530:6
<b>ppoerschke</b> 346:5	384:20,25 385:4	489:24 499:12	531:3 532:3
<b>practical</b> 431:10	385:12 386:24	500:9,15,16,22,22	<b>prescriptions</b>
432:2	387:4 399:4 410:1	500:23 501:5,8,15	360:8 362:1 368:5
<b>practice</b> 355:17	413:17,20 450:8	501:24,25	369:11 376:13,16
364:21 365:7	450:16,22 451:4	<b>prescription</b> 343:5	376:23 382:11
367:13,20 368:4	451:10 452:17	348:6 350:19	383:4,15 384:20
368:25 369:2	455:11,21,25	355:13,14 360:14	385:4,10,23
370:8,13,13,15	456:8 468:14,15	362:12 370:22	387:14 388:12
372:9,19 373:8	468:16 469:2	382:16 386:23	394:15,17 413:6
377:24 394:18	470:12 478:15	387:8 388:15	413:22 414:1,5,10
396:9,22 403:13	487:14 499:13,23	395:18,22,23	414:16,20,24
405:12 429:8	503:10 513:19	404:13,16,18	415:4,13 416:3,8
431:1 441:2 452:7	514:8,22 516:6,14	406:14,22,24	416:15,22 417:2,5
468:23 469:9,15	516:21 517:11,18	407:16 410:2	417:6 418:2,11,18
470:7,19 471:6	526:15	414:4,7 415:3,10	418:21 420:4,18
478:6,14,21 479:5	<b>prescriber's</b>	416:11,14 431:6,8	420:25 425:1,13
	449:19 450:19	431:23,25 432:12	431:13 435:24

## [prescriptions - provisions]

Page 29

437:9,18 438:10 438:17 443:1 444:15 445:5,8 446:3,8,17,18 447:6,17 449:19 449:24 450:4,9,20 450:23,24 451:4 451:12,21 452:9 452:10 453:10 455:25 459:7 460:11,15 461:21 462:18 463:25 464:4 466:4 469:18,21 470:1 472:1,2 474:18 483:11,23 484:14 487:12 499:13 502:19 503:18 504:19 505:15,18 505:20 506:1,7,10 507:6,8,11,15 508:11,18,22 509:15 510:15,19 511:11,16 514:7 516:21 519:13 523:20 524:3,9 525:17 526:3 <b>present</b> 346:8 436:16 489:11 528:23 <b>presentation</b> 404:12 <b>presented</b> 364:8 406:17 439:16 455:13 465:12 472:9 <b>presenting</b> 468:10 <b>presents</b> 522:17 <b>president</b> 458:22 461:16	<b>pressure</b> 460:10 464:2 <b>pressured</b> 459:17 <b>pretty</b> 462:13,14 <b>prevalent</b> 490:10 <b>prevent</b> 351:3 387:13 <b>preventing</b> 519:16 <b>previously</b> 493:4 493:12 <b>primarily</b> 467:6 <b>primary</b> 431:2 500:4 <b>principal</b> 392:5 <b>prior</b> 358:18 359:4 360:1,7 362:11 401:10 402:13 441:4 465:16 484:18 486:11 501:12 <b>probable</b> 408:14 <b>probably</b> 377:11 418:6 467:8 482:13,21 483:2 501:21 504:19 505:21 <b>problem</b> 375:22 376:4,6 395:20 396:1 484:20 <b>problematic</b> 401:9 402:12 513:20 <b>problems</b> 376:12 393:24 447:12 <b>procedure</b> 343:18 528:16 531:5 532:5 <b>procedures</b> 443:8 443:11 <b>proceed</b> 348:16 <b>proceeded</b> 453:15	<b>proceedings</b> 493:19 <b>process</b> 360:13 361:7,8,12 366:7 406:7,15,16 407:16 432:24 440:24,25 493:18 511:16 <b>processed</b> 511:11 <b>processes</b> 511:14 <b>processing</b> 440:23 <b>produced</b> 343:14 473:17,20 <b>product</b> 370:11 504:11 <b>production</b> 530:15 530:17,22 <b>products</b> 370:17 <b>professional</b> 355:17 383:22,25 386:12 399:14 449:3 456:24 513:18 514:7 515:21,23,24,25 518:8 <b>professionally</b> 515:18 <b>profile</b> 436:6,11 436:17,22 437:3,9 437:12,24 438:3,7 440:25 <b>profiles</b> 437:17 484:19 <b>program</b> 431:10 432:2 452:15,24 <b>programs</b> 434:5 457:10 480:16,18 480:19 484:19 <b>prohibited</b> 519:24 <b>promote</b> 477:7	<b>proper</b> 381:10 474:18 <b>proportion</b> 422:17 <b>prospective</b> 367:22 394:19 <b>provide</b> 352:11,23 358:3 360:12 361:6,19 362:20 364:7 372:8 387:25 394:16 409:2,4 411:5 412:14 417:19 419:12 428:18 434:2 449:17 507:1 <b>provided</b> 357:5 358:17 359:3 360:1 361:25 371:16 372:1 385:13 416:18 426:16 428:19,21 434:5 443:7,12 451:24 454:22 480:23 481:12 485:19 490:18,20 490:25 491:2 492:5 493:11 494:20,22 <b>providers</b> 478:23 <b>provides</b> 360:7 361:22 362:4,11 <b>providing</b> 375:23 388:24 461:3 <b>provision</b> 352:17 353:13,25 356:14 356:16 <b>provisions</b> 352:11 352:25 353:17 354:19 355:24 356:4,20 357:2,4 357:10,11,15
--	--	--	--

## [provisions - received]

Page 30

377:16 <b>public</b> 343:15 406:21 460:4 528:7 529:16 531:10,18 532:15 532:23 533:23 <b>publication</b> 428:13 <b>publish</b> 362:19,19 363:11,21 364:23 <b>published</b> 364:12 404:7 <b>pull</b> 348:25 392:11 499:21 <b>purchase</b> 428:23 <b>purchased</b> 452:15 <b>purpose</b> 370:23 393:6,7,23 396:17 404:3 420:19 435:1 442:1 443:16,21 447:6 450:9,18,23,25 451:5,13 453:11 461:22 511:18 523:10 525:5 <b>purposes</b> 383:5 385:2 444:16 511:20 <b>pursuant</b> 343:17 528:15 <b>put</b> 348:25 350:2 366:24 372:8 373:22 378:17 384:20 403:7 405:17 413:8 427:10 499:5 502:25 <b>puts</b> 498:12,19 <b>pweinberger</b> 344:12	<b>q</b> <b>qualify</b> 417:9,14 419:4 420:6 <b>quantify</b> 418:17 420:6,14 <b>quantities</b> 412:16 419:13 446:1,10 487:23 <b>quantity</b> 418:23 445:22 490:2 <b>question</b> 356:8,23 357:9 358:25 361:17 368:13,16 370:1,4 371:10 378:12 381:13 387:11 388:18 399:9,23 401:21 403:25 407:9 408:3 409:19 410:20 412:8 414:13 430:19 431:19 434:20 442:17 459:15 461:24 483:20 486:11 488:2 489:11 493:15,17 497:5 499:17 503:5,14 506:5 509:19 511:5 517:16 518:25 519:1 526:6,19 <b>questioner</b> 512:14 <b>questioning</b> 394:25 395:1 417:25 527:1 <b>questions</b> 347:3,5 347:6,8,9,11 348:20 357:2 378:10 421:13,18 422:13 429:15 438:15 466:16	467:4,12 475:18 483:6 510:13,25 512:10 513:2,5,7 520:1,6,10,12,16 521:6,22 522:3,6 522:13 524:18 526:8,11 527:3 <b>quick</b> 389:15,22 466:20 476:24 <b>quickly</b> 512:1 <b>quite</b> 359:14 <b>quote</b> 376:11 467:24 477:15 <b>quoted</b> 353:25 354:3	<b>readily</b> 441:7 <b>reading</b> 431:15,16 468:11 530:19 <b>reads</b> 374:22 401:4 402:8 406:25 <b>real</b> 466:19 476:24 <b>realize</b> 436:13 493:17 508:18 <b>really</b> 366:17 520:24 <b>realtime</b> 343:15 528:5 <b>reason</b> 361:1 389:20 416:9,16 417:7 418:3,12 467:23 468:2 471:2 487:17 503:1 513:12 514:23,25 530:14 532:8 533:3 <b>reasonable</b> 398:21 399:5,6,24 400:5 445:22 <b>recall</b> 362:22 376:4,6,19 377:1 379:12,19 429:22 458:2,4 465:20 474:5,7,10,14,16 474:21,23 481:19 496:20,23,24 497:4 515:10,12 516:8 <b>receipt</b> 530:18 <b>receive</b> 432:4 490:1 495:16 506:15 <b>received</b> 442:14 445:10 463:15 473:13 509:10
		<b>r</b> <b>r</b> 344:1,4 346:9,10 <b>rafferty</b> 346:2 <b>raised</b> 389:8 459:25 460:3 516:9 <b>ran</b> 426:1 488:14 488:20 <b>rang</b> 498:18 <b>range</b> 418:7 <b>rates</b> 477:3 480:8 <b>rays</b> 396:2 <b>reacting</b> 393:12 <b>read</b> 363:19 376:17 377:7 382:9 401:21 402:15 405:23 408:7 419:9 425:17 429:3,7 457:13 458:4 468:17 477:3,11 479:2 481:17 487:15 515:7,11 531:5,6,12 532:5,6 532:17	

## [receives - related]

Page 31

<b>receives</b> 361:9 370:21	497:14	486:16 489:15,17 489:22,24 490:11	<b>refreshing</b> 360:4
<b>receiving</b> 455:3,5 456:16	<b>recross</b> 347:10 526:10	492:1,8 493:10 494:3,13 499:12	<b>refusal</b> 383:2,20 384:7,15 385:16 386:5,10 387:13 388:4 516:10,12
<b>recess</b> 390:6 401:16 466:23 491:14 496:9 512:5 521:18 524:22	<b>red</b> 351:22,23 355:12,15 368:6 369:19 370:11 390:17 391:2 392:2 393:8,15,19 393:21,25 394:1 396:24 397:4,8,11 397:14,15,20,23 397:25 398:2,3,4,7 398:8,12,16,17,22 399:2,11,11,16,17 399:18,25 400:2,6 400:13 401:5 402:9 403:3 404:24,25 405:4 405:21 406:4 407:21 408:1,6,10 409:10 411:19 412:23,25 413:5 413:15,18,23 415:14,23 416:23 417:20 421:9 429:20 430:2,8,11 431:12 432:11 433:23 436:13 443:18,25 444:4,6 444:6 446:8 447:9 447:12 451:20 452:1,2,9,17 453:3 453:14 454:6,16 455:7,16,16,18,18 456:10 459:6,12 461:5 462:6 464:1 465:3 466:4 469:1 469:3,6,7,22,23 471:1,24 472:3,5 473:13,14 478:18 482:2 485:7	499:18,25 500:2,7 502:20 503:1,5 506:10 507:9 508:18 509:22,24 510:4,4,6,7 522:17 522:20,23 523:5,6 523:8,13,20,23 524:2,9 525:3,10 526:12,14	<b>refusals</b> 382:21 386:17 513:8
<b>recognize</b> 409:10	<b>recognized</b> 355:15	<b>redirect</b> 347:7 513:1 521:12 526:13	<b>refuse</b> 383:14 385:23 386:23 387:3 449:18 455:12 456:5 513:11 514:1,5 516:19
<b>recommendation</b> 465:14 466:1	<b>recommendations</b> 461:8	<b>reduced</b> 528:18	<b>refused</b> 382:10 384:22 385:9 405:17
<b>recommended</b> 446:4	<b>record</b> 348:2,14 375:13 380:21,25 390:4,9 401:14,18 430:25 436:2,4 466:19,21 467:1 471:14 491:6,9,11 491:12,16,19 496:5,7,11 497:12 512:2,3,7 516:17 520:21 521:13,16 521:20 524:19,20 524:24 527:8,9,11 528:20 532:9	<b>refer</b> 365:16 410:10 457:12 467:8	<b>refusing</b> 382:10,20 387:2
<b>recorded</b> 348:4 368:3 460:4 477:19 497:18 498:21 499:1,7 501:21	<b>recording</b> 368:7	<b>reference</b> 445:18 480:1 481:25 483:25 484:9 530:7 531:2 532:2	<b>regard</b> 450:2 509:10,22
<b>recordkeeping</b> 356:17	<b>records</b> 350:19 353:2,4 367:24 425:12 436:21	<b>referenced</b> 494:1 531:11 532:15	<b>regarding</b> 350:9 371:17 373:7 393:25 401:25 469:25 496:25
		<b>references</b> 475:7 476:1 482:14 483:3	<b>regardless</b> 514:20
		<b>referencing</b> 477:17	<b>regional</b> 394:13
		<b>referred</b> 380:7 492:15 517:7	<b>registered</b> 343:14 431:8,25 528:5
		<b>referring</b> 352:12 386:6 457:19 484:10 516:25	<b>registrant</b> 387:20
		<b>reflect</b> 367:18	<b>registrants</b> 447:24
		<b>reflected</b> 352:4,9 491:24	<b>regulation</b> 354:11
		<b>reflective</b> 367:14	<b>regulations</b> 363:21 372:19 381:18,23 479:23
			<b>regulator</b> 353:9
			<b>reimbursement</b> 405:13
			<b>related</b> 390:18 400:17 452:3 502:7



## [relates - responsibilities]

Page 32

<b>relates</b> 343:6 <b>relating</b> 355:12 438:3 463:4,11 <b>relationship</b> 435:3 435:19 436:9 <b>relationships</b> 434:11,18 <b>relative</b> 529:3 <b>relatively</b> 374:9 422:17 <b>released</b> 428:13,16 <b>relevant</b> 352:5,10 367:16 489:5 <b>relied</b> 391:1 476:11 479:6,14 482:8 <b>relies</b> 456:19 <b>rely</b> 354:19 356:4 357:17 393:20 476:6 480:13 <b>relying</b> 353:13,19 353:22 415:16 480:7 491:5 <b>remaining</b> 512:9 520:12 <b>remember</b> 384:5 395:8,10 430:3 452:13 467:13,17 483:5,7 <b>remote</b> 343:9 <b>remotely</b> 348:9 528:10 <b>repeat</b> 431:19 483:20 <b>repeatedly</b> 356:23 <b>rephrase</b> 430:19 442:18 <b>replied</b> 495:11 <b>report</b> 349:1,6 350:5,9 351:19,20 352:20 355:20	369:15 372:2 382:4,8 385:18,20 390:24 398:18 400:3 408:21 412:22 413:4,8 414:1 425:25 431:4 438:11 439:3,18 449:8,14 457:12,16 463:17 464:5 467:7,8 468:9,9,12,20 471:16 472:9,18 472:20,23 473:1,1 473:4,7,11,13,17 473:22 474:4 475:8,22 476:7,24 477:3,13 478:17 478:19 479:19 480:1 482:4,11,21 483:10 484:2 486:20 487:4,9 492:15,15,22,25 493:2 494:8,11,16 502:5 520:5 <b>reported</b> 385:8 480:22 <b>reporter</b> 343:15 343:15,15 348:12 348:18 363:5,7 401:12 528:4,5,6,6 529:15 531:7 <b>reporting</b> 360:17 360:22 361:2,11 455:21 <b>reports</b> 463:20 464:25 479:22 481:13 492:23 495:14 <b>represent</b> 353:11 421:20 467:6	<b>representative</b> 515:8 <b>represented</b> 377:20 479:20 528:24 <b>request</b> 377:15 426:14 431:3 437:8,12,13 464:25 532:9,11 <b>requested</b> 507:18 528:22 <b>requesting</b> 404:15 406:21 <b>require</b> 357:3 <b>required</b> 351:7,11 351:15 354:18 357:18 362:6,9 368:18 369:21 400:6 407:21 408:5 427:21 431:9 432:1 436:17,20,21,23 466:8 530:25 <b>requirement</b> 367:4 368:16,20 368:21 369:3 370:2,3 384:10 408:17 426:23 429:9 440:9 465:5 502:1 <b>requirements</b> 368:1 376:10 384:4 427:11 428:1 441:3 460:8 466:9 <b>requires</b> 355:4 366:25 368:4 370:13,14 427:13 429:1,19 <b>research</b> 359:9 475:3,7,12	<b>researched</b> 377:23 <b>researchers</b> 475:3 <b>residing</b> 529:21 <b>resolution</b> 355:15 394:13,14 395:13 407:21,25 408:5 408:12 429:20 430:2 433:23 459:6 461:5 462:6 463:18 523:13 <b>resolve</b> 355:13 368:6 394:24 409:10 415:23 431:12 432:11 455:17,18 <b>resolved</b> 417:20 436:14 443:21 444:1,6 446:8 456:9,13 506:11 508:19 510:5 522:20,24 523:6,8 523:21,23 524:10 525:4 <b>resolving</b> 430:11 525:10 <b>resources</b> 481:11 <b>respect</b> 465:10 520:15 523:4 <b>respectfully</b> 406:10 <b>respiratory</b> 484:22 <b>respond</b> 459:18 486:11 511:1 <b>response</b> 357:1 368:12 378:8 <b>responses</b> 438:16 <b>responsibilities</b> 352:3,9 355:8 393:11 394:19 396:22 428:3
---	---	--	---

<b>responsibility</b> 353:20 355:16 357:12,25 371:16 371:18 372:3 373:3,9 374:22 375:3 376:10,22 379:14,25 380:11 381:23 387:20,21 388:23 392:7,10 392:17 394:1,6,10 395:2 396:5,15 402:21 409:6,14 409:21 410:22 411:13 430:6 434:3 438:13 439:7,17 449:13 453:14 454:7 455:17 456:4 463:6,13 519:19 <b>responsible</b> 357:21 429:8 <b>rest</b> 448:16 466:8 <b>rested</b> 373:9 379:14 <b>restricted</b> 464:12 <b>rests</b> 411:4 <b>result</b> 405:22 412:14 413:4 419:11 451:21 525:9 <b>resulting</b> 417:12 <b>retail</b> 371:2 407:12 409:15,22 410:6,23 411:15 419:20 421:9 516:5 <b>retain</b> 350:18 <b>retention</b> 430:25 <b>returned</b> 530:18 <b>returning</b> 526:12	<b>reveals</b> 469:24 472:14 <b>review</b> 364:7 367:21,22 369:10 369:14 370:8 385:19 394:20 414:24 425:12 428:4 433:10 437:17,24 438:4 439:7 440:15 443:6 454:13,19 457:22 458:3 475:22 476:22 484:18 526:1 530:12 531:1 532:1 <b>reviewed</b> 360:17 361:8 386:7 443:11 454:11,18 458:4 478:1 479:23 481:14 492:22 <b>reviewing</b> 360:21 361:2 430:4 <b>rice</b> 344:3 522:12 <b>right</b> 352:13 354:14 355:22 359:18 363:3,24 364:13,17 365:11 365:14 366:21 369:15,22 370:21 371:25 372:4,10 372:12,16,24 373:4,8,11 374:5,6 374:9,23 375:8 381:13,25 382:17 382:21 383:11,17 385:25 391:3,7,18 391:22 392:3,22 392:23 393:16 395:24 396:16	397:16,23 400:14 400:19,23 402:1 402:19 403:16,18 403:22,24 404:8 404:19,25 405:6 405:14,18 406:12 406:19 407:14 408:1,24 410:8,18 411:23 412:20,23 413:2,6,9,20,24 414:7,10,16,22 415:4,15,17 416:3 416:9 419:16,25 432:18 444:7 454:18 457:21 462:16 465:18 467:9 469:24 470:4 473:9,24,25 477:11 479:1,6 481:21 482:17 484:10 485:24 487:4,19,20 496:4 496:13 502:1,7 503:22 504:2,10 504:12 505:8 506:20,23 512:21 512:23 514:24 519:7 526:20 <b>risk</b> 484:22 <b>rite</b> 345:15 421:20 421:24 437:2,8 439:5 443:6,12 450:3,5,8,12 457:12 458:9,24 459:5,8,11,15,25 460:1,19 461:20 462:1,4,5,7,16,20 463:8 486:1 494:9 494:15 502:11 521:5 525:1	<b>rmr</b> 529:14 <b>robert</b> 346:7 <b>role</b> 371:11 373:1 403:9 404:1 440:12 458:9,17 458:20 462:2 <b>room</b> 452:14 <b>row</b> 494:14 <b>rph</b> 343:9,14 527:18 528:9 530:8 531:4,9 532:4,13 533:20 <b>rules</b> 343:17 347:15 362:20 363:14,20 364:21 365:7 367:17,18 368:22,24 369:1,6 369:8 377:24 381:22 429:8 459:13 478:14,21 479:5 524:12 528:16 531:5 532:5 <b>run</b> 412:25 469:17 469:23 474:17 478:19 488:12,16 492:2 <b>rung</b> 498:18 <b>running</b> 491:7 495:12 <b>rushing</b> 389:2 <b>rx</b> 344:14 432:15
<b>s</b>			
<b>s</b> 344:1 530:15 532:8,8 533:3 <b>safe</b> 399:13 <b>saith</b> 527:14 <b>sake</b> 373:21 <b>sale</b> 497:17,21 498:11,18,25 499:1 501:15			



[sample - signatory]

Page 34

<b>sample</b> 454:22 455:6 509:10 <b>sat</b> 391:9 <b>saw</b> 360:15 381:2 480:25 <b>saying</b> 356:5 357:10 398:7,12 399:4 407:12 504:15 505:19 509:14,21 510:17 510:21 511:8,13 <b>says</b> 353:1,3 356:16 367:3,24 370:16 379:6 382:2 404:11 405:10,15,19,22 405:25 406:10,19 406:21 408:10 443:23 477:2 484:6 494:8 502:16 511:9 <b>scheduled</b> 343:17 <b>schierholt</b> 426:5 426:10 <b>science</b> 475:4 <b>scope</b> 453:12 454:6 526:16,25 527:4 <b>score</b> 452:20,21,22 452:23 <b>screen</b> 365:12,16 366:18 373:23 389:9 <b>scripts</b> 487:19 504:1 <b>scroll</b> 365:5 <b>seal</b> 529:8 531:15 532:21 <b>second</b> 353:7 362:13 374:4,14 374:25 376:8	378:23,24,24 379:4,4 394:16 395:17 397:9 401:4 402:5 412:13 419:10 494:3 <b>secondary</b> 508:5 <b>section</b> 350:9 352:15 353:7,20 364:20 365:6 366:15,20,23 367:3,9,23 372:3 374:21,25 375:2 375:10 380:24 397:8,11,11,14 400:16,16,25 401:25 403:8 404:10 427:11 429:22 476:24 477:1 483:15,18 484:10 <b>sections</b> 352:21,25 353:10,16,22,23 365:10 377:8 402:24 403:2 <b>secure</b> 462:15 <b>see</b> 350:11,20 354:3 356:25 364:20 365:5,7,10 365:12,16,19 366:15,20 374:4 376:2 379:1,2,10 382:13 387:5 389:10 397:8,20 397:22 399:3 401:11 409:11 477:2 478:24 487:7 489:18 491:18,22 495:19 502:11,21,22 505:1 509:19	521:2 <b>seeing</b> 365:1 387:9 415:9 478:10 <b>seek</b> 422:22 <b>seeking</b> 432:10 <b>seen</b> 375:15 385:15,21,24 444:5 <b>selected</b> 432:21 <b>selecting</b> 468:2 <b>send</b> 447:16 <b>sends</b> 379:23 447:10 <b>sense</b> 451:3 <b>sent</b> 349:19 381:21 490:16 <b>sentence</b> 350:20 350:22 376:8 378:17,24 379:4 401:4 402:5 408:6 412:13 419:10 472:14 479:2 <b>separate</b> 370:7 443:1 <b>september</b> 529:20 <b>series</b> 427:18 513:5 <b>serious</b> 432:17 433:17 <b>seriously</b> 376:11 <b>serve</b> 396:17 <b>served</b> 424:7 436:18 458:21 473:11 478:2 <b>service</b> 345:2 423:10,11 <b>serviced</b> 422:23,25 423:15,22 <b>services</b> 344:14 <b>set</b> 371:21 382:3 399:5 414:4	430:12 471:1 486:14 488:14 501:19,20 529:7 <b>sets</b> 485:19,22 <b>settlement</b> 457:13 457:14,24 <b>seven</b> 436:7 <b>shapira</b> 345:3 <b>shapira.com</b> 345:6 345:7 <b>shares</b> 521:5 <b>sheet</b> 530:13 532:7 532:10,18 533:1 <b>shibley</b> 344:9 <b>shopping</b> 377:21 467:12,16,20 468:19 471:16 475:5,13,20,23,25 476:4,7,9,13,23 477:5,16,16,18,20 478:13 479:16,18 480:9,23,25 481:3 481:4,18 482:5,9 <b>short</b> 374:9,15 421:13 471:8 509:1 <b>shorthand</b> 343:15 528:6 <b>show</b> 354:4 498:23 <b>showed</b> 488:14 <b>showing</b> 375:6 444:5 <b>shown</b> 476:9 530:16 <b>shows</b> 375:5 <b>sic</b> 420:13 <b>side</b> 493:22 <b>sign</b> 364:13 403:22 406:8 <b>signatory</b> 404:7
--	---	---	---

<b>signature</b> 528:22 529:13 530:14	351:4,5,9,13,18,25 352:7,15 353:23	408:22,25 409:12 409:18 410:10,19	465:21 466:18 467:10,14,18,22
<b>signed</b> 367:3 368:22 370:2 405:2,19 531:13 532:18	354:8,22 356:11 357:7,16 359:14 359:19 360:4,11 360:18,20,24	411:1,19,24 412:21,24 413:3,7 413:10,14,17,21 414:8,12,18,25	468:1,18 469:4,12 469:18,22 470:3,5 471:19 472:9,15 473:15 474:7,21
<b>significance</b> 521:24 522:16,18	361:17 362:8,23 363:4,9,17,23,25	415:7 416:10 417:10,18 418:8	474:25 475:9,15 475:21,24 476:4
<b>significant</b> 412:16 416:25 417:10,13 417:14 418:5,5,15 418:15,20,21,23 419:1,1,5,13 420:3 420:7,7,13,15,25 421:2,11 444:10 444:15 445:18 459:13 462:14 489:10 490:8,10 492:6 506:6,17 509:23 524:2	364:3,14,18,22 365:9,13,19 366:3 366:13,19,22 367:6,10 368:24 369:13,24 370:7 371:14,22 372:5 372:11,13,17,21 372:25 373:5,10 373:12,14,17 374:3,7,10,24 376:3,6,18 377:1,6 377:9,18 379:2,5 379:11,19 381:16 381:19 382:2,7,14 382:18,23 383:8 383:12,19,23 384:6,11 385:17 385:20 386:2,14 386:24 387:6,18 388:9,17 390:21 390:25 391:4,8,12 391:19,24 392:4,6 392:11,16,20,24 393:4,17 395:6,17 396:11 397:5,10 397:13,18,25 398:11,14,20,25 400:3,9,15,20,24 401:3 402:16,20 403:1,19,25 404:9 404:20 405:1,8,20 406:9,10,16 407:10 408:2,9,17	418:13,22 419:2,6 419:17 420:1,21 421:4,11,15,23 422:2,11,17,24 423:5,13,18,25 424:5,9,16 425:5 425:11,14,17,24 426:3,5,8,13,17,22 427:24 428:2,6,17 429:22 430:11 431:3,15,18 432:6 432:15 433:5,18 434:9,14,20 435:6 435:15,22 436:1,3 436:14 437:5,21 438:2,6,8,16,24 439:11,23 440:3 440:10,19 441:9 441:14,19 443:4,9 444:8,23 446:6,16 447:2,8 448:6,10 448:14,18 449:1 449:11 450:21 451:3,16,24 452:11 453:7,16 454:1,8,17 455:15 456:14,21 457:2 457:19,22 458:5,8 458:19 459:21 460:23 461:1,13 461:17,24 462:19 462:22 463:1 464:13,16 465:7	476:16 477:12,14 477:19 478:12,25 479:4,10 481:20 482:15,21 483:1,7 483:13 484:12,16 484:25 485:2,5,10 485:15,23 486:3 486:14,21 487:2,8 487:16,21 489:3 489:13 491:21 492:3,10,23 493:3 493:15 494:6 495:1,9,12,15,18 495:21,24 496:3,3 496:16,20 497:5 497:18,22,25 498:9,25 499:9,19 500:12,18 501:1 501:12,13,21 502:3,8,13,22 503:13,23 504:5 504:15,21 505:3,7 505:24 508:16,23 509:20 511:4,22 525:23 530:10
<b>signing</b> 530:19			<b>sitting</b> 357:1,5 359:23 417:25 418:13 420:16
<b>signs</b> 390:17 392:3 396:25 405:11			<b>situation</b> 442:5,6 463:19 481:7,10
<b>similar</b> 452:21 468:13 481:5,8,17			<b>situations</b> 405:22 459:19 471:6,9 499:21
<b>simply</b> 392:18 394:14 432:24 453:13 470:14 489:17			
<b>simultaneous</b> 375:12 480:3 519:23			
<b>sincerely</b> 530:21			
<b>single</b> 359:23 444:25 465:11 513:19 514:6 522:16,23 525:7 526:2			
<b>sir</b> 348:18,23 349:3,5,9,13,16,22 350:4,7,12,16			

[small - store]

Page 36

<b>small</b> 365:20 <b>smaller</b> 423:12 <b>smallest</b> 422:10 <b>smith</b> 388:12,15 <b>software</b> 496:17 <b>sold</b> 454:4 <b>solely</b> 456:5 <b>solutions</b> 348:11 530:1 533:1 <b>somebody</b> 399:4 461:11 <b>someone's</b> 389:9 <b>sorry</b> 371:24 389:2,14,16 401:13 402:4 407:9 414:12 453:24 463:7 476:25 483:13 488:2,25 494:10 497:22 500:12 502:8,10 512:13 512:15,22 518:20 520:18 522:9 524:16 526:23 <b>sort</b> 364:1 392:7 <b>sought</b> 434:18 <b>sound</b> 467:9 <b>sounds</b> 457:21 <b>source</b> 430:23 431:2 <b>sources</b> 480:15,16 481:20 483:2 <b>south</b> 343:16 344:6 346:3 376:15 528:14 <b>spaeder</b> 344:15,19 <b>spangenberg</b> 344:9 <b>spanglaw.com</b> 344:12	<b>speak</b> 392:6 404:7 425:15,20 426:10 448:7 457:8 460:19 <b>speaking</b> 380:19 <b>special</b> 346:10 390:1 491:7 520:20 526:17,19 526:20,25 <b>specialmaster.law</b> 346:12 <b>specialty</b> 405:12 <b>specific</b> 352:25 355:24 356:4 373:2 399:11 402:24 410:5,7,22 411:14 417:1 422:22 423:14 424:18 429:22 441:6 445:4 447:19 457:16 465:20 475:21 525:13,20 <b>specifically</b> 352:22 355:3,6 356:18 358:20 395:11 429:18 430:1,3 444:23 448:20 453:7 464:20 515:10,12 520:8 <b>specifics</b> 481:19 <b>specify</b> 410:11 427:18 <b>speculate</b> 420:17 <b>speculation</b> 420:21 451:7 <b>spoke</b> 460:1 479:17 492:19 <b>ss</b> 528:1 <b>st</b> 346:3	<b>staff</b> 364:7 461:11 492:4 495:14,23 496:2 <b>staffing</b> 462:20,23 462:25 464:11 <b>stakeholder</b> 390:14 391:13,21 403:21 502:6,15 <b>stakeholders</b> 390:17 392:17 393:8,14 394:11 394:23 395:5 396:24 397:7,12 398:5,9 401:25 402:18,20,23 403:11,17 405:3 <b>stamp</b> 498:23 499:23 501:7,11 <b>stand</b> 392:13 476:5 <b>standard</b> 358:22 448:12,14,17 479:21 481:9 <b>standards</b> 399:20 481:5,17 <b>start</b> 401:21 <b>started</b> 381:7 519:2 <b>starts</b> 391:22 484:10 <b>state</b> 343:16 347:15,18 352:5 352:10,12 357:17 357:20,24 362:21 363:14 364:11,16 367:13,14 369:1,2 370:15 371:5 372:7,10 373:2,4 373:10 374:1 376:23 377:3 379:12,21 381:20	385:8 427:8,9,16 427:19,22 428:10 428:19 429:18 431:1,9 432:1,14 432:19 433:1 439:10 451:19 457:24 461:3 462:17 463:20 466:15 528:1,7 531:10 532:15 <b>stated</b> 430:1 467:24 476:6 499:6 519:10 <b>statement</b> 480:8 481:17,22,24 531:13,14 532:19 532:19 <b>states</b> 343:1 352:18 354:4 355:1 357:21 358:2 361:18 368:12 372:12 427:12 428:11 430:5 436:20 465:14 480:20 502:16 <b>status</b> 437:14 <b>steering</b> 480:17,18 <b>stenographer</b> 507:18 <b>stenographic</b> 528:4,18 529:15 <b>stepping</b> 457:20 520:25 <b>steps</b> 433:21 434:1 <b>steve</b> 426:5 <b>stick</b> 355:22 <b>stop</b> 380:19 395:14 <b>store</b> 350:18 351:22 369:18
---	---	---	---

[store - system]

Page 37

384:16 422:23 423:1,15,22 424:7 424:11,11 425:2 <b>stores</b> 344:14 386:16 421:24,24 422:5,14 423:7,9 424:2,4 426:16 <b>street</b> 344:16,20 345:13,17,22 <b>strength</b> 487:13 500:5 501:4,6 <b>strengths</b> 487:23 490:2 <b>strike</b> 378:7 396:25 411:8 423:7 425:7 450:15 458:15,16 460:5 476:5 480:5 497:8,10 <b>stringent</b> 476:15 <b>students</b> 428:21 428:21 <b>study</b> 475:4 <b>submit</b> 503:6 <b>subscribed</b> 531:10 532:14 533:21 <b>subsequent</b> 412:13 419:11 <b>subset</b> 413:1,23 <b>substance</b> 355:13 356:13 385:5 400:18 401:6 402:9 404:16 406:22 431:6,13 431:23 432:12 433:10 434:25 441:13,16,24 442:25 459:7,16 460:21 468:11,13 477:9 493:16 519:13	<b>substances</b> 351:3 352:5,10,18 353:2 353:6,17 354:18 355:24 358:6,12 369:6 375:24 385:11 390:19 411:18 412:16,19 418:23 419:14,16 419:22 428:1 429:2 433:24 452:20 456:1 465:16 476:25 477:6 478:16,16 480:10 524:11 <b>substantiate</b> 356:15 415:21 510:13 <b>subtle</b> 401:7 402:10 <b>sue</b> 453:9 <b>suggest</b> 381:1 <b>suggesting</b> 517:1 <b>suggestion</b> 381:4 <b>suggests</b> 477:6 <b>suite</b> 344:11,17,21 345:9,13,23 346:11 530:2 <b>summary</b> 408:23 409:2 <b>superior</b> 530:1 <b>supervised</b> 425:18 <b>supervisor</b> 379:8 379:17,25 <b>supplemental</b> 349:1 467:7 484:1 494:4 <b>supply</b> 417:22 467:20 <b>support</b> 387:25 391:2 392:23 481:16	<b>supported</b> 403:16 403:17 <b>supporting</b> 449:25 <b>supports</b> 420:13 <b>supposed</b> 384:1 <b>sure</b> 349:21 354:14 359:10 361:23 365:22 370:20 375:15,16 377:19 386:6 392:18 401:20 404:2 423:7 424:24 430:25 431:15,20 432:9 433:21 437:14 439:12 440:10 442:21 457:17 465:24 476:17 477:25 480:14 482:12,13 498:8 499:17 511:6 516:10,17 521:9 521:11 <b>surge</b> 401:13 <b>surrounding</b> 431:7,24 <b>survey</b> 427:1,5,8 427:17,25 428:4,7 428:15,18 429:4 429:13,17,23 <b>suspected</b> 383:6 <b>suspicion</b> 405:5 <b>suspicious</b> 351:1 351:16 385:24 387:9 414:7 431:7 431:24 <b>sussane</b> 515:8 <b>sustained</b> 526:17 <b>swanson</b> 345:22 347:3 348:15,20 348:22 352:16	353:18 354:13,23 355:21 356:24 357:13 358:14,23 359:11 360:9,25 362:2,16 363:10 364:10,25 365:3,4 365:17,22 366:1 367:7 369:12,25 370:24 371:9,19 373:24 374:19,20 375:8,19 377:2,10 377:13 378:7,11 378:14,20,22 379:20 380:19 381:4,12 382:24 384:13 386:8,15 386:25 388:3,10 388:19 389:5,11 389:25 390:3,11 391:14 392:12,21 393:5 394:8 396:6 396:12 397:6,19 398:1 399:1,22 400:4,10 401:19 402:7 403:15 405:9 406:18 407:3,11 408:18 410:3,13 411:8,11 411:20 412:1,12 414:14,19 415:1 415:12,24 416:6 417:3,15 418:9 419:3,8,24 421:1,5 421:12,16 513:7 523:16 524:6 <b>sworn</b> 343:14 528:10 531:10,13 532:14,18 533:21 <b>system</b> 360:10,16 360:18,22 361:2,3 361:6,11,11,13,23
--	---	--	--

[system - time]

Page 38

362:3,10,13 366:10,11,25 368:2,6 369:14,16 369:20 370:18 371:8,8 411:23 412:18 419:15,22 420:5 440:1,6,16 440:22 456:12 497:1,4,14,16,18 499:8 522:21 <b>systems</b> 350:18 351:21 356:7 365:11 366:5,6,13 366:16,21,24 367:25 371:1,7,13 409:15,17,22 410:5 412:9 436:20 440:19,21 441:5 497:13,19 497:24 498:5,6,8	<b>talked</b> 362:17 371:18 372:2,6,22 412:23 430:10,10 449:21 467:15 471:5 <b>talking</b> 368:14 387:1 406:12 440:19 473:10 499:4 505:3 516:18 <b>talks</b> 353:7 367:20 367:21,22 430:6 464:5 <b>tara</b> 345:9 347:8 512:1 513:2 520:25 <b>task</b> 459:11 462:16 <b>team</b> 364:1 366:24 <b>tech</b> 498:12 <b>technician</b> 498:19 <b>technology</b> 366:8 369:7 <b>tell</b> 352:17 389:12 408:4,4 414:9 417:4,16,17 418:1 457:8 459:4 461:14 471:21 488:17 508:12 528:11 <b>telling</b> 379:22 <b>tells</b> 388:11 503:18 503:20,24 <b>ten</b> 498:4 519:6 520:2 521:7 <b>tenets</b> 464:21 <b>term</b> 420:8,8,15 421:4 <b>termed</b> 402:18 <b>terms</b> 369:7	<b>terrific</b> 348:25 363:18 <b>test</b> 414:5 486:7,8 <b>tested</b> 445:16 <b>testified</b> 380:23 475:11 493:4,12 495:25 508:16 516:1 518:2 524:1 525:3 <b>testify</b> 475:15 <b>testifying</b> 356:5 473:24 526:12 <b>testimony</b> 354:15 355:10 356:3 358:7 361:13 380:17 384:5 400:7 415:19 419:18 474:3 485:21 491:23 507:9 511:12 522:23 524:7 528:21 531:6,7 532:6,9,12 <b>tests</b> 432:8 <b>text</b> 494:23 <b>tfumerton</b> 345:11 <b>thank</b> 348:18,24 349:17 365:3,25 367:12 371:22,23 401:23 421:15,16 431:18 457:19 466:17,18 491:22 513:3,3 522:8 527:6 <b>thanks</b> 360:4 365:22 374:19 512:10 <b>therapies</b> 471:11 <b>therapy</b> 455:4 470:11,11 471:3,7 471:7,12	<b>things</b> 362:18 372:6 381:18 393:13,14 394:7 399:19 466:10 494:7 510:22 521:4 <b>think</b> 356:11 364:15,24 375:4,4 380:11,17 381:3 389:7 395:9 399:5 421:13 422:2,8 430:17 438:15 462:13 464:13 471:5 475:11 488:23 489:8 491:5 498:25 499:6 500:1 501:19 502:18 503:19 504:18 505:19 506:4,22 510:25 518:13 521:4 527:7,10 <b>third</b> 364:20 396:18 405:13 <b>thirty</b> 530:18 <b>thought</b> 368:14 386:4 396:7 403:25 407:22 418:14 447:24 514:11 522:3 <b>thousand</b> 416:21 504:1 505:7 <b>three</b> 343:7 352:21 360:18,22 365:6 422:9,18 487:11 487:20 500:24 501:3,5 522:6 <b>tight</b> 389:2 <b>time</b> 348:2 360:15 365:15 367:10 373:21 376:19
<b>t</b>			
<b>table</b> 364:19 484:5 <b>tagged</b> 416:23 <b>take</b> 365:15 378:1 378:4,16 384:8,22 389:15 390:2 402:24 435:2 441:12,16,23 442:6,9 506:24 <b>taken</b> 343:16 348:5 357:15 376:9 390:6 401:16 426:19 459:11 462:16 466:23 491:14 496:9 497:13 512:5 521:18 524:22 528:13,17 <b>takes</b> 459:16 <b>talk</b> 369:15 390:16 430:7 476:18			

[time - unduly]

Page 39

377:8,11 378:17 380:8 389:2 421:13 425:25 433:2,18 435:11 440:9,13 442:4 448:25 450:24 452:13 459:20 460:5,7,12,12 462:9,19 463:3,4 463:11,11 464:2 465:8 473:25 476:18 484:19,24 491:7 498:7,11,21 498:23 499:23 500:5,6 501:6,11 512:9 514:21 518:17,21,23 519:2 520:1,10,15 520:16,17,25 521:7 <b>times</b> 356:22 357:10 370:6 458:21 <b>title</b> 363:19 <b>tn</b> 344:14 <b>today</b> 348:12 349:8 357:1,5 359:8,23 378:2 390:8 417:24,25 418:14 420:16 466:25 520:11 <b>today's</b> 405:12 <b>told</b> 381:20 503:9 <b>ton</b> 503:25 <b>tool</b> 393:1 410:22 410:23 411:14 <b>tools</b> 361:24 368:9 387:25 388:24 409:5 410:10,12 410:14 412:15 419:12	<b>top</b> 487:4 494:9 <b>topic</b> 382:5 <b>topics</b> 372:14 <b>total</b> 357:16 417:11 441:3 472:1 486:14 <b>totals</b> 417:22 <b>track</b> 343:7 530:6 531:3 532:3 <b>train</b> 350:25 <b>trained</b> 431:5,22 433:22 <b>training</b> 434:6,7 442:13 443:6 <b>transacted</b> 497:18 <b>transaction</b> 497:21 499:4 <b>transacts</b> 499:1 <b>transcribed</b> 531:7 <b>transcript</b> 348:16 521:1 528:20 530:11,12 531:5 531:12 532:5,11 532:17 <b>traveled</b> 413:19 526:15 <b>traveling</b> 404:13 404:23 <b>travels</b> 399:3 <b>tremendous</b> 375:21 <b>trends</b> 409:8 <b>trial</b> 525:25 <b>triggered</b> 351:24 <b>trinity</b> 486:16 <b>trouble</b> 442:16 <b>true</b> 357:6 360:2 372:20 377:4 391:10 418:3 434:12 440:5 457:1 464:8	528:20 <b>trumbull</b> 420:11 421:22 422:13,15 423:1,10,16,23 424:3,8 425:2,10 425:22 434:17 439:22 442:24 443:14 444:12,18 444:25 445:20,23 446:14 448:3,7,21 450:5,17 451:10 453:24 454:4 462:21,24 464:10 464:13 466:7 526:2 <b>trust</b> 387:8 <b>truth</b> 528:11,11,12 <b>try</b> 349:25 362:25 364:17 376:23 394:24 <b>trying</b> 389:8 484:12 493:16 505:16 522:4 <b>turn</b> 353:24 354:1 366:18 376:7 397:21 408:20 413:11 419:9 502:5 <b>turns</b> 378:1 <b>two</b> 352:21 353:16 357:4 362:8 404:23 416:20,21 417:23 422:19 444:10,14 445:11 446:3,21 467:15 467:21 470:2,10 471:2 472:5 484:23 494:1 495:24 510:25 521:14	<b>type</b> 385:7 427:23 <b>types</b> 405:10,22 <b>typewriters</b> 498:8 <b>typewriting</b> 528:19 <b>typewritten</b> 528:20
<b>u</b>			
<b>u.s.</b> 348:7 <b>ultimate</b> 364:8 <b>unaware</b> 475:19 <b>understand</b> 351:19 356:8 358:24 377:15 378:8,8 394:4 396:20 398:10 414:12 419:18 423:4 424:22 429:14 431:16 436:13 437:12 442:9 448:14 455:19 464:17 479:15 488:2 499:3,6 504:6 509:19 511:1 517:13 522:4 <b>understanding</b> 356:11 393:11 407:9 433:6 435:11,23 442:17 447:8 449:5,6 453:17 457:17 492:24 495:9 513:22 514:11 516:24 517:25 <b>understood</b> 406:17 493:5 495:2,7,11 513:10 514:20 <b>unduly</b> 459:17			



## [unexplainable - warrants]

Page 40

<b>unexplainable</b> 404:13 <b>unit</b> 348:3 <b>united</b> 343:1 358:2 361:18 <b>unknown</b> 470:12 <b>unlimited</b> 519:5 <b>unquote</b> 376:11 467:24 477:15 <b>unreasonably</b> 404:14 <b>unresolved</b> 443:18 444:4 <b>updated</b> 428:17 <b>updates</b> 429:11 <b>upsetting</b> 395:24 <b>urge</b> 520:24 <b>use</b> 351:7,11,15,21 352:18 354:5,16 355:1 357:3,18 368:18 369:16 381:9 386:20 388:5,14 410:7 453:2 467:25 468:4 481:8 485:1 <b>useful</b> 489:13,20 <b>uses</b> 358:16 359:2 359:24 360:6 362:10 367:1 <b>utilization</b> 367:21 367:22 369:10,14 370:8,9 394:20 438:4 477:7 <b>utilize</b> 350:23 361:10 370:18 399:13 <b>utilized</b> 366:8 369:4 371:2 465:15 480:22 481:11	<b>utilizing</b> 369:9 409:7 <b>utmost</b> 356:18  <b>v</b> <b>v</b> 530:6 <b>vaccine</b> 361:5 <b>valid</b> 519:15 <b>valuable</b> 482:1 <b>variety</b> 366:6 <b>various</b> 392:17 458:21 460:3 516:2 517:20 <b>vary</b> 422:9 423:2,5 424:10,13 442:4 <b>verbal</b> 459:23 492:3 <b>verbally</b> 494:2 <b>verify</b> 469:4 <b>veritext</b> 348:10,12 530:1,7 533:1 <b>veritext.com.</b> 530:17 <b>versus</b> 417:21 419:1 425:1 <b>video</b> 343:9 348:4 389:12 <b>videographer</b> 346:6 348:1,11 390:4,7 401:14,17 466:21,24 491:12 491:15 496:7,10 512:3,6 521:16,19 524:20,23 527:11 <b>view</b> 357:3 366:11 371:5 376:20 377:3 379:13 382:19 386:9 388:13 397:1 404:21,21 416:24 417:5 419:18 437:23 439:4	446:12 449:2 450:3,15,16 455:9 456:4,15,23 460:20 478:18 525:9 <b>viewed</b> 403:3 <b>views</b> 466:10 <b>violated</b> 356:6 439:6 <b>violates</b> 519:19 <b>violating</b> 380:10 438:12 <b>violation</b> 358:6 <b>virginia</b> 376:15 <b>virtual</b> 371:11 <b>visit</b> 413:19 503:4 526:15 <b>visited</b> 452:18 <b>volkman</b> 430:8 433:14 <b>volume</b> 343:10 348:4  <b>w</b> <b>w</b> 344:16 <b>wacker</b> 345:9 <b>wag</b> 363:2,2,3 373:16 389:3 <b>wag19-1-9</b> 362:25 <b>wait</b> 378:13 <b>waived</b> 530:19 <b>walgreen</b> 345:20 345:20 <b>walgreens</b> 345:20 382:8,10,15,19,20 383:9 384:18 385:15,21 386:3 394:21,22 395:4,7 395:10,20 396:8 396:13 403:6 411:3 413:22 420:18 439:5	485:25 494:9,14 502:11 <b>walmart</b> 345:8 439:5 486:1 494:9 494:15 502:11 513:10,17,24 514:4,12,21 515:1 515:11 516:2,25 517:1 518:7 519:14 <b>walmart's</b> 514:14 515:7 518:9 519:10,12 <b>want</b> 354:14,24 355:22 356:2,3 375:13 377:25 378:15,23 380:24 390:16 391:16 397:20 401:1 409:1 410:4 413:11,15 419:9 421:6 430:12 451:4 457:16 473:24 484:11 485:12,17 491:18 502:14 514:21 516:17 519:3 521:11,12 527:2,3 <b>wanted</b> 396:13 398:5,9 400:13 485:3 487:9 492:2 <b>wants</b> 428:23 432:17 <b>warning</b> 390:17 392:3 396:25 405:11 518:7 <b>warrant</b> 405:4 <b>warranted</b> 477:7 508:21 <b>warrants</b> 401:10 402:13
--	--	--	---

[washington - zwier]

Page 41

<b>washington</b> 344:21 <b>watch</b> 520:24 <b>way</b> 352:20 359:16 366:17 368:7 396:4 414:22 416:1 417:9 459:22 461:24 470:13,17,21 471:1 487:5 507:5 515:17 521:10 523:14 <b>ways</b> 410:7 <b>we've</b> 352:3 401:12 412:22 482:18 507:12 <b>webinar</b> 427:14 <b>wednesday</b> 343:17 528:15 <b>week</b> 436:8 <b>weeks</b> 360:18,22 <b>weinberger</b> 344:10 <b>went</b> 381:14 392:22 404:6 441:4 498:7 <b>west</b> 345:9 <b>wewatta</b> 345:22 <b>whereof</b> 529:7 <b>whichever</b> 365:18 <b>white</b> 459:12 <b>willfully</b> 443:19 444:3 <b>willingly</b> 443:22 <b>winsley</b> 433:13,17 <b>wisconsin</b> 518:6 <b>witness</b> 343:14 355:25 365:25 378:19 380:20,23 380:23 389:7,18 389:20 401:12	421:15 466:18 478:2 512:8 524:15,16 529:7 530:11 531:1,4,11 532:1,4,15 <b>witnesses</b> 458:12 <b>witness'</b> 530:14 <b>wolf</b> 344:4 <b>wondering</b> 368:20 469:6 <b>word</b> 378:25 407:23 <b>work</b> 350:25 360:10 425:22 426:12 435:17 441:21 445:21 446:24 468:22 475:8 497:24 <b>workbook</b> 427:14 <b>worked</b> 359:12,16 360:5 425:16 426:20 434:16 442:23 493:7 496:13,14,17 515:18 <b>working</b> 359:17 361:3 441:22 469:8,15 470:6 492:14 <b>workings</b> 439:10 <b>works</b> 436:7 <b>worry</b> 349:25 <b>write</b> 350:17 351:4 352:2 362:19 372:14,18 403:2 450:22 451:4 <b>writing</b> 380:16 383:4 385:1 386:22 416:12 450:24 459:4,22 470:10 474:11	475:22 <b>written</b> 372:2 383:15 388:12 395:19 414:21 416:9,15 417:7 418:2,12 429:10 444:16 467:21 470:2 472:16 478:17 487:13 490:24 491:2,2 <b>wrong</b> 378:5 382:20 <b>wrote</b> 381:1,2,5 414:10,15 431:21 469:24 470:4 477:13	<b>zuckerman.com</b> 344:18,22 <b>zwier</b> 345:4,6
		<b>x</b>	
		<b>x</b> 396:2	
		<b>y</b>	
		<b>yeah</b> 374:13 469:6 520:8 <b>year</b> 480:20 <b>years</b> 353:9 359:12 498:4 <b>yesterday</b> 349:11 353:25 354:8 362:17 364:15 372:6,22 377:20 383:24 467:11 471:5 475:17,17 476:9 479:20,22 480:4 483:5 492:17 494:1 507:14	
		<b>z</b>	
		<b>zero</b> 381:4 <b>zinmaster</b> 511:25 <b>zuckerman</b> 344:15 344:19	



Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS  
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

Veritext Legal Solutions complies with all federal and State regulations with respect to the provision of court reporting services, and maintains its neutrality and independence regardless of relationship or the financial outcome of any litigation. Veritext requires adherence to the foregoing professional and ethical standards from all of its subcontractors in their independent contractor agreements.

Inquiries about Veritext Legal Solutions' confidentiality and security policies and practices should be directed to Veritext's Client Services Associates indicated on the cover of this document or at [www.veritext.com](http://www.veritext.com).